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Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1985

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

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QUESTION PRESENTED

Whether a taxpayer using the accrual method of tax accounting is entitled to deduct, as a fixed liability at the close of its taxable year, an addition to a reserve for future expenses expected to be paid under an employee medical reimbursement plan, where the addition is based on the taxpayer's estimate of its liability to employees who were assumed to have received medical care during the year, but who had not submitted claims for payment, or whose claims for payment had been submitted but not approved, before the close of the taxable year.

PARTIES TO THE PROCEEDING

In addition to the parties named in the caption, Datagraphix, Inc., Material Service Corporation, Marblehead Lime Corporation, and General Dynamics Land Systems, Inc. (formerly Stromberg-Carlson Corporation), are respondents. Each is a wholly-owned subsidiary of General Dynamics Corporation.

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The Solicitor General, on behalf of the United States, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Federal Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-5a) is reported at 773 F.2d 1224. The opinion of the Claims Court (App. *infra*, 6a-18a) is reported at 6 Cl. Ct. 250.

JURISDICTION

The judgment of the court of appeals (App., *infra*, 20a) was entered on September 19, 1985. On December 9, 1985, the Chief Justice extended the time within which to petition for a writ of certiorari to and including February 16, 1986 (a Sunday preceding a federal legal holiday). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTES INVOLVED

The relevant portions of Sections 162, 446 and 461 of the Internal Revenue Code of 1954 (26 U.S.C.), and of Sections 1.446-1 and 1.461-1 of the Treasury Regulations on Income Tax (26 C.F.R.), are set out in a statutory appendix (App., *infra*, 21a-26a).

STATEMENT

1. For many years respondent General Dynamics Corporation and its subsidiaries have been required by collective bargaining contracts to maintain health insurance coverage for their employees. Under these health plans, employees pay the first $100 of covered charges (generally called "the deductible") before becoming eligible for benefits. After that, employees generally are entitled to reimbursement for 80% of the covered medical costs that they or their dependents incur (C.A. App. 64). Certain items—such as expenses related to pregnancy and childbirth, the costs of footcare and eyeglasses, the costs of "check-up examinations and tests not reasonably necessary to medical treatment"—are not covered by the plans (*id.* at 54, 56). In the case of otherwise-covered items, employees are not entitled to reimbursement if the treatment is for work-related injuries, if the treatment is furnished by an unapproved practitioner, if the expenses are incurred within 30 days of an employee's entry into the plan, or if the expenses are attributable to certain pre-existing conditions (*id.* at 54, 57, 61-62; PX 47, at 41-48, 51-52). The plans specify a maximum amount allowable per illness, a maximum amount allowable for each particular treatment or procedure, and a daily limit on hospital charges (C.A. App. 48-50, 55). The plans also specify that reimbursement will not be made for

expenses in excess of the provider's usual charge for a particular treatment or procedure, or in excess of a stated percentage (generally 85% or 90%) of the customary charge prevailing in the neighborhood (*id.* at 56; PX 47, at 33-36).

To be entitled to reimbursement under respondent's health plans, a covered employee must submit a claim for benefits on a standard form (App., *infra*, 7a). The claim must be accompanied by itemized bills evidencing the amount paid and specifying the diagnosis and treatment given (*id.* at 7a-8a; C.A. App. 58). Respondent has no obligation to make any payment unless and until an employee has submitted a properly-documented claim for benefits and the claim has been determined to qualify for payment under the terms of the plans.

2. Prior to October 1, 1972, respondent supplied the health benefits outlined above by purchasing group medical insurance from two outside carriers, Aetna Life Insurance Company and Prudential Insurance Company. Insurance companies are generally required by state law to maintain certain reserves with respect to the insurance coverage that they provide. In the case of the medical insurance coverage that Aetna and Prudential provided to respondent's employees, both companies prior to October 1, 1972, maintained reserves for health claims that they estimated (1) had arisen, but had not yet been reported to them, or (2) had been reported to them, but had not yet been processed or approved for payment (App., *infra*, 8a). These reserves represented a statistical estimate, based on each carrier's past experience, of the amount that it would ultimately have to pay with respect to such actual or potential claims. Reserves of this sort are usually called "incurred but not reported," or "IBNR," reserves (*ibid.*). Under

the special tax provisions applicable to insurance companies, an insurance company, unlike other taxpayers, is generally permitted to deduct additions to reserves (including IBNR reserves) that are required by state law. See I.R.C. §§ 807 (life insurance companies), 832(b)(5) (casualty insurance companies).

On October 1, 1972, respondent became a self-insurer of its health care plans. Although respondent thus ceased paying premiums to Aetna and Prudential, those companies continued to administer the plans for a fee under service agreements (App., *infra*, 7a). This shift to self-insurance entailed no change in the medical benefits provided to respondent's employees; from their perspective, the only difference was that their health-benefits checks thenceforth were drawn on a different bank. Respondent's shift to self-insurance likewise entailed no change in the claims-processing procedure or in the personnel responsible for implementing it; employees' claims continued to be screened in the first instance by the claims department at respondent's plants, and then to be forwarded to the insurance company for evaluation and approval (*ibid.*).

On the date respondent became a self-insurer, it agreed to pay all health claims that Aetna and Prudential had previously reserved against. On the same day, respondent took an amount equal to the aggregate IBNR reserves that Aetna and Prudential had previously maintained for those claims, and set that amount up as a liability on its own books. On December 31, 1972, using statistics supplied by those companies, respondent calculated an estimate of its liability to employees who were assumed to have received medical care during the last three months of 1972, but who had not submitted claims, or whose

claims had been submitted but not approved, as of that date. The amount thus calculated was added to the beginning IBNR reserve balance that respondent had inherited from the insurance companies. Respondent then calculated the amount that it had actually paid out on approved claims during the final quarter of 1972. That amount was subtracted from the reserve balance. See App., *infra*, 8a-9a; C.A. App. 27-33. These calculations produced a year-end IBNR reserve balance in the amount of $5,575,289, representing respondent's estimate of its anticipated liability to pay benefits on claims arising from pre-1973 medical treatment. App., *infra*, 10a; C.A. App. 34-35.

During 1973 and 1974, respondent actually paid out $4,583,893 in benefits on claims arising from pre-1973 medical treatment (App., *infra*, 16a). This sum was approximately $1 million (or 17.8%) less than the amount that respondent had reserved to pay such claims (*ibid.*). It has been the experience of Aetna and Prudential that about 90% of the amounts for which respondent's employees claim reimbursement are actually approved for payment (*id.* at 12a). As to the balance, the claims are rejected in whole or in part because the expenses for which reimbursement is sought are not covered by the health plans, because a specified maximum charge has been exceeded, because the treatment is not deemed medically necessary, or because the employee's expenditure otherwise fails to qualify for reimbursement under the terms of respondent's plans.

3. Respondent uses the accrual method of accounting for federal tax purposes. On its consolidated federal income tax return for calendar year 1972, respondent originally did not deduct any portion of its IBNR reserve in computing its tax (C.A. App.

34). In 1977, however, after the IRS had commenced an audit of that return, respondent filed an amended return for 1972, claiming that it was entitled to a deduction under Section 162 of the Code[1] in the amount of $5,575,289—the 1972 year-end balance of its IBNR reserve—as an "ordinary and necessary [business] expense[ ] paid or incurred during the taxable year." See C.A. App. 37-38.

The Commissioner denied respondent's claim for refund. He noted that, under the accrual method of tax accounting, an expense may not be deducted until "all of the events have * * * occurred which fix the liability" (Treas. Reg. § 1.461-1(a)(2)). The Commissioner determined that the events which would fix respondent's liability to pay for a particular employee's medical treatment would be that employee's submission of a properly-documented claim for reimbursement, and respondent's determination that the claim qualified for payment, in some future tax year. Until those events occurred, the Commissioner concluded, respondent's obligation to pay was contingent and hence gave rise to no deductible expense.

Following the denial of its administrative claim for refund, respondent filed this refund suit in the Claims Court. That court ruled for respondent (App., *infra*, 6a-18a). It held that the last event necessary to fix respondent's liability to reimburse its employees occurred "when a qualified employee or dependent receive[d] covered medical services" (*id.* at 11a, 13a). In the court's view, an employee's submission of a claim for benefits, and respondent's evaluation of the claim with a view to determining whether or not it

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[1] Unless otherwise noted, all statutory references are to the Internal Revenue Code of 1954 (26 U.S.C.), as amended (the Code or I.R.C.).

qualified for payment, constituted mere "clerical," "administrative," or "ministerial" steps that were not "condition[s] precedent to establishing the fact of liability" (*id. at* 12a). The court held, moreover, that respondent, in order to establish the fact of its liability, was not required to demonstrate "any specific liability to particular employees who received treatment" (*id.* at 9a). Rather, it was sufficient for respondent to "estimate [its] aggregate liability" to its employees as a group, basing its estimate on a statistical probability that a certain quantum of covered medical services had been rendered to covered recipients (*ibid.*). The court noted that respondent's method of computing its IBNR reserve "reflected accepted insurance company practice" and that "insurance companies can and do deduct such reserves" (*ibid.*). The court concluded that respondent was entitled to deduct the entire 1972 year-end balance of its IBNR reserve as a salary expense "incurred during the taxable year" (I.R.C. § 162(a)).

The Federal Circuit affirmed (App., *infra*, 1a-5a). It stated that the issues had been "thoroughly treated in the trial court's opinion" and that the only question "which [it] need[ed] to address on appeal" was whether the decision below was contrary to Court of Claims precedent (*id.* at 1a-2a). The Federal Circuit answered that question in the negative and proceeded to "affirm * * * on the basis of the Claims Court opinion" (*id.* at 5a).

REASONS FOR GRANTING THE PETITION

This case presents an important question of federal tax law. The decision below is squarely at odds with fundamental principles that this Court has enunciated to govern accrual of deductions under the "all events" test of tax accounting, and it conflicts with

the decisions of other courts of appeals that have applied those principles. The decision below produces an irrational result: by permitting respondent to take a current tax deduction for estimated liabilities based solely on extrapolations from past experience, that decision would permit the deduction of expenses that respondent may never incur at all. The question presented here is related to, but has considerably broader implications than, the question now pending before this Court in *United States* v. *Hughes Properties, Inc.*, No. 85-554, also on certiorari to the Federal Circuit. Given the prevalence of employer-sponsored medical reimbursement plans, the revenue impact of the decision below, rendered by a court of nationwide jurisdiction, is substantial. Review by this Court is therefore appropriate.

1. a. Section 162(a) of the Code allows a deduction for "all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business." A taxpayer who uses the "cash receipts and disbursements method" of accounting (I.R.C. § 446(c)(1)) is entitled to deduct business expenses only in the year in which they are paid (Treas. Reg. §§ 1.446-1(c)(1)(i), 1.461-1(a)(1)). A taxpayer who uses the "accrual method" of accounting (I.R.C. § 446(c)(2)), by contrast, is entitled to deduct expenses in the year in which they are "incurred," regardless of when they are actually paid (I.R.C. § 162(a); Treas. Reg. § 1.461-1(a)(2)).

For almost sixty years, the standard for determining when an item of expense is to be regarded as "incurred," and hence as being properly deductible for federal tax purposes, has been the "all events" test. First enunciated by this Court in *United States* v. *Anderson*, 269 U.S. 422, 424 (1926), the test was subsequently incorporated in the Treasury Regula-

tions. It has two elements, both of which must be satisfied before accrual of an expense is proper. First, "all the events [must] have occurred which establish the fact of the liability giving rise to [the] deduction" (Treas. Reg. § 1.446-1(c)(1)(ii)). Second, the amount of the deduction must be able to "be determined with reasonable accuracy" (*ibid.*). While the second part of the test permits a degree of computational flexibility, the Regulations emphasize that the first part of the test is absolute: "no accrual shall be made in any case [unless] all of the events have * * * occurred which fix the liability" (Treas. Reg. § 1.461-1(a)(2)).

In determining whether a liability has become "fixed," and thus constitutes an "expense incurred during the taxable year" for federal tax purposes, this Court long ago made clear that "a liability does not accrue as long as it remains contingent." *Brown* v. *Helvering*, 291 U.S. 193, 200 (1934). "The prudent businessman," Justice Brandeis wrote for the Court, "often sets up reserves to cover contingent liabilities. But they are not allowable as deductions." *Lucas* v. *American Code Co.*, 280 U.S. 445, 452 (1930) (footnote omitted). To be deductible for federal tax purposes, "the obligation to pay [must] ha[ve] become final and definite." *Security Flour Mills Co.* v. *Commissioner*, 321 U.S. 281, 287 (1944). It must be "fixed and absolute." *Brown* v. *Helvering*, 291 U.S. at 201. It must be "unconditional." *Lucas* v. *North Texas Lumber Co.*, 281 U.S. 11, 13 (1930). It must not be "contested by the taxpayer." *Dixie Pine Co.* v. *Commissioner*, 320 U.S. 516, 519 (1944). "[T]he tax law requires," in short, "that a deduction be deferred until 'all the events' have occurred that will make it fixed and certain." *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. 522, 543 (1979)

(quoting *United States* v. *Anderson*, 269 U.S. at 441).

b. Contrary to the Claims Court's statement (App., *infra*, 13a), respondent's liability to reimburse its employees for their medical expenses was not "fixed and certain," was plainly not "unconditional" or "absolute," at the close of its 1972 taxable year. Under its collective bargaining contracts, respondent had no obligation to pay any medical benefits unless and until (1) an employee submitted a properly-documented claim for reimbursement and (2) respondent and its agents satisfied themselves that the claim qualified for payment under the terms of the health plans. The obligation represented by respondent's IBNR reserve was contingent at the close of its 1972 tax year because, as to every putative obligee, one or both of those conditions had not been met.

In constructing its IBNR reserve, respondent made an assumption that an indefinite number of its employees had received medical services during 1972. As respondent conceded, however, many of those supposed recipients had not submitted any claim for reimbursement before the year ended. It was entirely possible, moreover, that some of those individuals would never submit a claim at all. Some might regard the medical expenses that they had incurred as too insignificant to warrant the trouble of seeking reimbursement. Some might not wish their employer's agents to know that they had undergone treatment for certain medical conditions. And some might fail to submit claims because of inadvertence or neglect. Since respondent had no obligation to pay medical benefits unless an employee filed a claim therefor, respondent's liability to these potential claimants was neither "unconditional" nor "absolute" at the close of its 1972 tax year.

The balance of the employees in question had submitted claims to respondent, but their claims had not been determined to qualify for payment as of December 31, 1972. As to each claimant in this group, respondent reserved the right to contest its liability to make reimbursement on the grounds (inter alia) that the medical procedure was not covered by the health plans, that stipulated maximum charges had been exceeded, that the treatment was not medically necessary, or that the expenditure otherwise failed to qualify as a "covered medical expense." Although the trial court characterized the claims-processing procedure as "ministerial" and "routine" (App., *infra*, 12a), the court in fact found that only 90% of the amounts claimed by respondent's employees, on average, were actually approved (*id.* at 12a-13a). Since there thus existed a substantial possibility that any particular claim would be denied in whole or in part, respondent's liability to these claimants, like its liability to those employees who had not filed claims at all, was neither "unconditional" nor "absolute" on the last day of 1972.

The trial court sought to avoid this conclusion by reasoning that respondent's liability became "fixed * * * upon occurrence of the insured event—the receipt of covered services by the insureds" (App., *infra*, 15a). But this reasoning merely assumes what respondent was required to prove. Respondent made no attempt to ascertain whether any employee had in fact received medical services, much less that any employee had received *covered* medical services, before the close of its tax year. Obviously, respondent could not have shown that unless it had looked at its employees' claims to see if they qualified, something that respondent by hypothesis had not done. Rather, respondent simply *assumed*, based on projections from past experience, that a certain dollar

volume of covered services had been rendered to an indeterminate number of unknown workers.

Such an assumption is incompetent as a matter of law to "establish the fact of the liability" (Treas. Reg. § 1.446-1(c)(1)(ii)) under this Court's decisions. Those decisions require that a deduction be deferred until *all the events* have occurred that fix the taxpayer's liability *absolutely* and *unconditionally*. An assumption that one has incurred an obligation in an estimatible amount cannot constitute proof of an "unconditional liability" if words are to retain their meaning. Respondent's liability was to pay medical benefits to *individuals* upon their satisfaction of certain conditions precedent. It has long been clear that a liability becomes "fixed" only when it is based on known facts respecting individual claimants; it cannot be based on projections of aggregate liability suggested by past experience. Indeed, the Federal Circuit's predecessor itself held that "[t]he *individual items* must represent fixed liabilities" and that the fact (as opposed to the amount) of liability "cannot be approximated or estimated." *Union Pac. R. Co.* v. *United States*, 524 F.2d 1343, 1351 (1975) (emphasis added; original quotation marks omitted). The burden of proving deductions is on the taxpayer (*Helvering* v. *Taylor*, 293 U.S. 507, 514-515 (1935)), and respondent simply failed to prove that, by this standard, it had become liable to any individual as of the date its tax year closed.

Because respondent did not demonstrate the existence of a fixed and unconditional obligation as of the close of its taxable year, it failed to "establish the fact of [its] liability" (Treas. Reg. § 1.446-1(c)(1)(ii)) as required by the first part of the "all events" test. Under these circumstances, it is immaterial whether the actuarial data supplied by re-

spondent's plan administrators would have enabled it to satisfy the *second* part of the "all events" test, on the theory that the *amount* of its contingent liability, given those statistical projections, could "be determined with reasonable accuracy" (*ibid.*). As this Court's decisions make clear, the two parts of the "all events" test erect discrete and independent requirements, and *both* must be satisfied before a deduction is allowable.[2]

2. In permitting respondent to take a current deduction for a contingent future expense, the decision below also conflicts in fundamental principle with this Court's decisions emphasizing the critical differences between tax and financial accounting. As we have pointed out at greater length in *United States* v. *Hughes Properties, Inc.*, 85-554 U.S. Br. at 21-29,[3] Congress has vested the Commissioner with "broad powers in determining whether accounting methods used by a taxpayer clearly reflect income" (*Commissioner* v. *Hansen*, 360 U.S. 446, 467 (1959)). Congress's decision in that respect owes in part to "the vastly different objectives that financial and tax accounting have." *Thor Power Tool Co.*, 439 U.S. at 542. "The primary goal of financial accounting is to provide useful information to management, share-

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[2] We argued below that respondent's actuarial data in fact did not enable "the amount [of its liability to] be determined with reasonable accuracy" (Treas. Reg. § 1.446-1(c)(1)(ii)) for purposes of the second part of the "all events" test, pointing out in this connection the $1 million differential between the reserve amount that respondent sought to deduct and the sums that it actually paid. See App., *infra*, 16a. Although we believe that the courts below erred in rejecting our argument (*id.* at 5a, 16a-17a), we are not presenting for review here the question of respondent's ability to satisfy the second part of the "all events" test.

[3] We have furnished a copy of that brief to respondent's counsel.

holders, [and] creditors" and "to protect these parties from being misled" (*ibid.*). Financial accounting accordingly "has as its foundation the principle of conservatism, with its corollary that possible errors in measurement [should] be in the direction of understatement rather than overstatement of net income" (*ibid.*; original quotation marks omitted). "[T]he major responsibility of the Internal Revenue Service," by contrast, "is to protect the public fisc," so that "understatement of income is not destined to be its guiding light" (*ibid.*). Given this diversity, even contrariety, of objectives, to say that a taxpayer's accounting practice " 'is in accord with generally accepted commercial accounting principles' * * * is not to hold that for income tax purposes it so clearly reflects income as to be binding on the Treasury." *American Automobile Ass'n* v. *United States*, 367 U.S. 687, 693 (1961) (footnote omitted).

This Court's cases demonstrate that divergence between tax and financial accounting is especially common where, as here, "a taxpayer seeks a current deduction for estimated future expenses or losses" (*Thor Power Tool Co.*, 439 U.S. at 541). Financial accounting rules, implementing the principle of conservatism, "typically require that a liability be accrued as soon as it can reasonably be estimated" (*id.* at 543 & n.20 (citing authorities)). Accruals of such anticipated liabilities are commonly made by establishing on the corporation's books a reserve account to cover amounts reasonably expected to be paid in the future. See, *e.g.*, *Commissioner* v. *Hansen*, 360 U.S. at 448 (reserve to cover contingent liability in event of nonperformance of guarantee); *Brown* v. *Helvering*, 291 U.S. at 196-197 (reserve to cover expected liability in event of insurance policy cancellations); *Lucas* v. *American Code Co.*, 280 U.S. at 447 (re-

serve to cover contingent liability on contested lawsuit).

"Only a few reserves voluntarily established as a matter of conservative accounting," however, "are authorized by the Revenue Acts." *Brown* v. *Helvering*, 291 U.S. at 201-202. Among the reserves so authorized are those maintained by insurance companies. Congress for many years has provided that insurance companies generally may claim current tax deductions for specified additions to their reserves. See I.R.C. §§ 807 (life insurance companies), 832(b)(5) (casualty insurance companies). Consistently with that statutory authorization, the insurance companies from which respondent bought insurance prior to October 1, 1972, presumably deducted their year-end additions to their IBNR reserves, and those deductions were presumably allowed. See App., *infra*, 8a. Respondent, however, is not an "insurance company," a term that is defined with great precision in the Code. See I.R.C. §§ 816, 831. Respondent had no license, simply by electing to become a self-insurer, and by establishing on its books the same IBNR reserve previously used by Prudential and Aetna, to claim a deduction to which insurance companies alone are entitled.

Contrary to the Claims Court's reasoning, therefore, it is irrelevant that respondent's method of computing its IBNR reserve "reflected accepted insurance company practice" and that "insurance companies can and do deduct such reserves" (App., *infra*, 9a). The propriety of respondent's deduction must be judged, not by principles applicable to insurance companies, but by the "all events" test applicable to taxpayers generally. That test "is designed to assure that taxpayers will not obtain deductions for expenditures that might never occur," and it thus "seeks certainty of liability rather than probability."

World Airways, Inc. v. *Commissioner*, 62 T.C. 786, 805 (1974), aff'd, 564 F.2d 886 (9th Cir. 1977) (citing *Brown* v. *Helvering*, 291 U.S. at 201)).

The courts below ignored these precepts in sustaining respondent's deduction. There was surely a probability that many of respondent's employees who had visited a doctor or hospital during 1972 would subsequently file claims for reimbursement. And there was likewise a probability—apparently in the range of 90%—that those claims, if submitted, would be determined to qualify for payment. Thus, "the principle of conservatism" (*Thor Power Tool Co.*, 439 U.S. at 542) may have required respondent to set up a reserve for those items at once and show them as a liability on its books. "[B]ut the accountant's conservatism cannot bind the Commissioner in his efforts to collect taxes" (*id.* at 543). Although "estimates, probabilities, and reasonable certainties * * * may be useful, even essential, in giving shareholders and creditors an accurate picture of a firm's overall financial health," the tax law, "with its mandate to preserve the revenue, can give no quarter to uncertainty" (*ibid.*). The tax law requires that a taxpayer establish his liability as an unconditional fact, and respondent failed to do so.

As this Court noted in *American Automobile Ass'n*, 367 U.S. at 694-697, Congress once adopted, albeit only briefly, provisions that would have permitted taxpayers to deduct anticipated expenses by a reserve mechanism identical to that used by respondent. As originally enacted in 1954, Section 462 of the Code allowed a deduction for "a reasonable addition to [a] reserve for estimated expenses," with "estimated expenses" being defined to include deductions "attributable to the income of the taxable year or prior taxable years." Internal Revenue Code of 1954, ch. 736, § 462(a) and (d)(1)(B), 68A Stat. 158-159. Sec-

tion 462 was designed to bring "[t]ax accounting more nearly in line with accepted business accounting * * * by allowing reserves to be established for known future expenses." S. Rep. 372, 84th Cong., 1st Sess. 3 (1955). Congress explained that Section 462 would allow taxpayers to deduct estimated amounts of "certain liabilities for self-insured injury and damage claims," precisely the types of claims at issue here. See H.R. Rep. 1337, 83d Cong., 2d Sess. A163 (1954); S. Rep. 1622, 83d Cong., 2d Sess. 63, 305-307 (1954).

The change brought about by Section 462 was short-lived. Congress repealed that provision retroactively less than one year later, prompted by warnings from the Treasury Department "that the proposed endorsement of such [methods of] accounting would have a disastrous impact on the Government's revenue." *American Automobile Ass'n*, 367 U.S. at 695. The taxpayer in *American Automobile Ass'n* contended that Congress's retroactive repeal of this provision should not be interpreted to preclude use of the reserve method of tax accounting that it employed, but the Court held that this contention "'varnish[ed] nonsense with the charm of sound'" (367 U.S. at 695). "[T]he cold fact," the Court said, "is that [Congress] repealed the only law incontestably permitting the practice upon which the [taxpayer] depends" (*ibid.*).

Congress thus has specifically considered and, upon reconsideration, rescinded a provision that would have achieved the very result that the court of appeals here adopted. That court had no license, by misapplying the "all events" test, to resurrect the rule that Congress deliberately discarded.

3. The decision below also conflicts, either directly or in fundamental principle, with numerous appellate

decisions that have denied deductions in circumstances substantially similar to those here. It often happens that a taxpayer is under a present obligation —be it statutory, regulatory, or contractual—to make specified future payments upon the happening of specified future events. Relying on decisions like *Brown* v. *Helvering*, *supra*, the lower courts have held that such generalized and incomplete obligations cannot justify current tax deductions under the "all events" test, correctly reasoning that such liabilities remain contingent until the requisite future events have transpired.

In *Trinity Construction Co.* v. *United States*, 424 F.2d 302 (5th Cir. 1970), for example, an employer had a contractual obligation to pay future premiums on policies insuring the lives of key employees, and it sought a current deduction for the premium payments expected to be made over the contract term. The Fifth Circuit denied a deduction; it noted that the employer's liability was contingent on the employees' being alive when the premiums were due, and it held that an expense may be deducted "only in the taxable year when the obligation to pay it is unconditionally fixed" (424 F.2d at 305). In *Bennett Paper Corp.* v. *Commissioner*, 699 F.2d 450 (8th Cir. 1983), an employer had a contractual obligation to make future payments to a profit-sharing plan on account of employees' past services, provided that the individuals were still employed when the payments were due. The Eighth Circuit denied a current deduction; it noted that "the forfeiture provision made the * * * liability a contingent liability," and it held that a "liability is not fixed until all the conditions for payment are met" (699 F.2d at 453). In *World Airways, Inc.* v. *Commissioner*, *supra*, an airline had a contractual obligation to make future pay-

ments for statutorily-required engine overhauls, and it sought a current deduction for amounts expected to be paid over the contract term. The Tax Court denied a deduction; it noted that the taxpayer "was under no obligation to make any payment unless an overhaul was actually performed," and it held that an expense is not deductible unless the taxpayer's liability is "absolutely fixed in the year of accrual" (62 T.C. at 802, 804).

The rationale of these cases shows the error of the holding below. Respondent had a contractual obligation under its collective bargaining agreements to reimburse employees for their medical expenses upon their satisfaction of certain conditions. The employees were required to submit a claim for benefits; they were required to document their claims with itemized bills; and they were required to satisfy respondent that the expenses they had incurred qualified for reimbursement under the terms of the health plans. Respondent had no obligation to make a payment to anyone until those conditions had been met, and, in the case of the amounts reflected in respondent's IBNR reserve, one or more of those conditions had not been met as of December 31, 1972.

4. The question presented here is of great importance to the administration of the revenue laws. The Internal Revenue Service advises that there are currently pending administratively 57 cases that involve the deductibility of IBNR reserves by corporations having self-insured medical reimbursement plans. Approximately $113 million in taxes is involved in those cases alone. The importance of the question, moreover, is not limited to cases involving medical plans, but extends to cases involving any sort of self-insured liability, from an employer's liability under a workers' compensation statute to a shipper's liability

under a contract of carriage. Indeed, in repealing Section 462 thirty years ago, Congress was motivated largely by a Treasury Department estimate that the use of reserve methods of accounting for tax purposes would produce a transitional revenue loss in excess of $1 billion. See *American Automobile Ass'n*, 367 U.S. at 697 n.12; H.R. Rep. 293, 84th Cong., 1st Sess. 3 (1955). That figure would doubtless be a good bit higher today.

As we have noted, the question presented here is related to that now pending before the Court in *United States* v. *Hughes Properties, Inc.*, No. 85-554, which also involves the proper timing of deductions under the "all events" test. The question there is whether a gambling casino using the accrual method of tax accounting is entitled to deduct, as a fixed liability at the close of its taxable year, the amounts registered on the "jackpot indicators" of its progressive slot machines, even though it has no obligation to pay such amounts unless and until the jackpots are won by its patrons in some future year. Although the instant case raises a similar legal issue, it presents a question of substantially broader implications, involving as it does the ability of taxpayers to deduct mere estimates of liability based on projections from past experience. Given the prevalence of self-insurance plans among this country's major corporations, moreover, the factual setting of the instant case is far more typical of the problems that confront the Commissioner and taxpayers alike in this difficult area of the law. The Court's decision in *Hughes Properties* will not necessarily be dispositive of the outcome here, and we believe that this case warrants the Court's plenary review.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

CHARLES FRIED
Solicitor General

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FEBRUARY 1986

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

No. 85-760

GENERAL DYNAMICS CORP., ET AL., APPELLEES

v.

THE UNITED STATES, APPELLANT

DECIDED: September 19, 1985

Before FRIEDMAN, RICH, and BISSELL, *Circuit Judges.*

BISSELL, *Circuit Judge.*

The United States (government) appeals from the judgment of the United States Claims Court, entered on September 10, 1984, granting General Dynamics Corp. and its subsidiaries (taxpayer) a refund of federal income taxes of $31,708 (plus interest). We affirm.

OPINION

The issues presented in this court, with one exception, were thoroughly treated in the trial court's opinion filed by Judge Seto, reported at 6 Cl. Ct. 250 (1984). The one issue which we need to address on

appeal is the government's contention that the Claims Court's application of the "all events test" in Treas. Reg. § 1.461-1(a)(2) (1984) is contrary to precedent binding upon this court.[1]

Taxpayer, an accrual basis taxpayer, is a self-insurer of its medical care plan. It deducted, as an expense on its federal income tax return, an estimate of its liability to pay for medical care for employees who had obtained treatment but whose claims had either not yet been filed or had not been processed at the end of the taxable year in issue. The Claims Court found that taxpayer's claimed deduction met the "all events" test for deduction of an expense by an accrual basis taxpayer. An accrual basis taxpayer is entitled to deduct an expense in the taxable year in which *all the events have occurred* to establish *the fact* of the liability for the expense and fix *the amount* thereof with reasonable accuracy. Treas. Reg. § 1.461-1(a)(2) (1984).

The government argues that even though the Claims Court decision may be supported by the law of another circuit, *Kaiser Steel Corp. v. United States*, 717 F.2d 1304 (9th Cir. 1983), it is in conflict with the law of this circuit as expressed in *Eastman Kodak Co. v. United States*, 534 F.2d 252 (Ct. Cl. 1976). We believe the government's interpretation of *Eastman Kodak* is unwarranted. When one reads *Eastman Kodak* in conjunction with *Washington Post Company v. United States*, 405 F.2d 1279 (Ct. Cl. 1969), and *Inland Steel Company v. United States*, 212 Ct. Cl. 558 (1976), one understands that an

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[1] In *South Corp. v. United States*, 690 F.2d 1368 (1982), this court adopted the Court of Claims precedent as binding upon it.

affirmance of the trial court's judgment is not contrary to the law in this circuit.[2]

With regard to the first prong of the "all events test," the government emphasizes that it is the law in this circuit "that the *fact of liability* is measured on an item by item basis, rather than as an overall estimate." *Eastman Kodak*, 534 F.2d at 258 (emphasis in original). Since taxpayer failed to determine the fact of its liability on an employee by employee basis, the government's position is that *Eastman Kodak* requires reversal of the trial court.

The statement extracted by the government from that opinion, in context, related to the analysis as to whether for each employee the fact of liability is certain and not subject to future events. In the case at bar the Claims Court held that the last event necessary to fix the fact of liability was the occurrence of the insured event, the receipt of covered medical services. As the court explained, taxpayer was "not predicting the happening of future events: rather, [it was] estimating the amount of fixed liability for events which had already occurred." 6 Cl. Ct. at 255. That result is not contrary to *Eastman Kodak* which required that "Kodak must show that the fact of payroll tax expense for the given employee was *certain for each employee* as of the end of [the tax year]." 534 F.2d at 258-59 (emphasis in original). The complicating feature of the payroll tax which

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[2] Counsel for the government, although aware that a panel of this court is bound by prior precedential decisions unless and until overturned *in banc*, overlooks the fact that "statements in opinions of this court must be read harmoniously with prior precedent, not in isolation." *Kimberly-Clark Corporation v. Fort Howard Paper Company*, No. 85-902, slip op. at 6 (Fed. Cir. Sept. 6, 1985).

the *Eastman Kodak* court addresed was the yearly ceiling on the tax. "The effect of the ceiling is to create a degree of uncertainty in determining, as of the end of a given year, at what time or for how many months an employer will have to pay tax during the next year for each individual employee." 534 F.2d at 259. The ceiling created uncertainties as to the payroll tax on bonuses and vacation pay because events in the subsequent year, an intervening pay raise and the timing of a vacation, would affect the fact of liability. That situation does not obtain here for there were no events in the subsequent year which would alter the fact of liability. Just as the taxpayer in *Inland Steel* became committed to ultimately pay the prescribed amount of liability as hourly services were rendered by employees during the taxable year, 212 Ct. Cl. 560, so the taxpayer here became committed to pay prescribed amounts of liability as covered medical services were received by each employee during the taxable year.

With regard to the second prong, the government argues that *Eastman Kodak* requires that the reasonable accuracy of the amount deducted be based on each claim, reminding us that "[t]he test must be applied to each employee on an individual basis." *Eastman Kodak*, 534 F.2d at 261. Since taxpayer failed to calculate the amount of its liability on an employee by employee basis, the government's position again is that *Eastman Kodak* requires reversal. Again the government's interpretation of *Eastman Kodak* is unwarranted. The second prong of the test is whether the amount of liability "is reasonably *ascertainable* for each employee." *Eastman Kodak*, 534 F.2d at 261 (emphasis added). *Eastman Kodak* did not hold that the amount of liability must be

actually *ascertained*. The trial court in this case properly rejected the necessity for actual ascertainment on an employee by employee basis where in a situation such as this a canvass of taxpayer's 56,000 employees was theoretically possible, but obviously would have been prohibitively expensive and overly burdensome.

In the light of the foregoing, we believe the judgment of the Claims Court is not contrary to our precedent. Accordingly, we affirm that judgment on the basis of the Claims Court opinion.

Affirmed.

APPENDIX B

IN THE UNITED STATES CLAIMS COURT

No. 7-81T

GENERAL DYNAMICS CORPORATION, ET AL.

v.

THE UNITED STATES

(Filed: September 7, 1984)

OPINION

SETO, *Judge.*

In this action, plaintiffs request an income tax refund based on an accrued expense deduction which was disallowed by the Internal Revenue Service for the taxable year 1972. The issue before the court is whether the fact and amount of plaintiffs' liability is certain enough for the purpose of determining an accrued expense deduction. For the reasons set forth below, the court concludes that the deduction should be allowed and that plaintiffs are entitled to a refund.

FACTS

A three-day trial was held in St. Louis, Missouri where plaintiffs introduced the testimony of various expert witnesses, along with an extensive stipulation of facts. Defendant accepted the majority of plaintiffs' factual assertions, but disputed plaintiffs' claims as a matter of law.

Stromberg-Carlson Corporation, DatagraphiX Inc., Material Service Corporation, Marblehead Lime Co., Freeman Coal Corporation, and United Electric Coal Companies (hereinafter "plaintiffs") are, and were in 1972, wholly-owned subsidiaries of General Dynamics Corporation, a Delaware corporation with its principal office in St. Louis, Missouri. In 1972, plaintiffs used an accrual method of accounting with a fiscal year coinciding with the calendar year.

From 1962 until October 1, 1972, plaintiffs purchased group medical insurance from Aetna Life Insurance Company ("Aetna") for some of plaintiffs' offices and from Prudential Insurance Company of America ("Prudential") for other offices. This insurance included medical care benefit plans for plaintiffs' employees and their qualified dependents. In the last quarter of 1972, plaintiffs became self-insurers for their medical care plans. Aetna and Prudential continued to work with plaintiffs under separate Administrative Services Agreements, whereby the insurance companies administered the self-insured plans for the locations that each insurance company had previously insured for plaintiffs. There were no changes in medical benefits provided or in the personnel who were handling the claims-processing procedure.

The claims-processing procedure was straightforward. When an employee or qualified dependent received medical treatment covered by the plan, the employee obtained payment for the treatment by submitting a health-expense benefits claim form to plaintiffs' employee-benefits personnel office at the appropriate facility. The claim form contained pertinent information about the employee and the treatment, including the date and cost of each medical service. Claim forms, with itemized bills attached, were

checked against personnel records to verify that the persons making the claims were eligible under the plan at the time of treatment. Eligible claims were sent to Aetna or Prudential, depending on the facility of origin, for final processing and payment. Drafts were issued either on plaintiffs' account or from one of the insurance companies' accounts pursuant to an automatic funds-transfer arrangement with plaintiffs.

The period between the rendering of medical services and the payment for such treatment was labeled a "lag time" by plaintiffs. For example, on December 31, 1972, plaintiffs had neither received all of the claim forms which would be filed for medical services rendered in 1972, nor completely processed all filed claims. Consequently, plaintiffs established reserve accounts to reflect their liability for medical care received during the last quarter of the calendar year 1972, but unpaid as of December 31, 1972. As accrual-basis taxpayers, plaintiffs deducted expenses not when actually paid, but rather in the taxable year in which they were incurred. The reserves were substantially similar to those established by Aetna and Prudential to reflect their accrued liability for incurred but not yet reported claims ("IBNR" reserves). Prior to October 1, 1972, Aetna and Prudential deducted their IBNR reserves in the taxable year the services were received. Plaintiffs sought advice from Aetna and Prudential concerning accurate estimation of liability for medical care benefits. They were advised that the liability for unpaid benefits could be reasonably determined as a percentage of the payments for medical benefits actually made during a prior period of equal length. The percentage figure was based upon an analysis of plaintiffs' ex-

perience with lag between accrual and payment of claims.[1]

Plaintiffs' method of computing their reserves did not reflect any specific liability to particular employees who received treatment; rather, plaintiffs estimated their aggregate liability. While plaintiffs admit that it would have been theoretically possible to canvass their employees in an effort to determine the approximate amount of their liability, as of December 31, 1972, such a procedure would have been prohibitively expensive and overly burdensome. Thus, plaintiffs used what they claim was the most reasonable method for estimating their liability in the aggregate—a method derived from procedures developed by the insurance companies. *See* note 1. Plaintiffs' evidence that its methods reflected accepted insurance company practice was essentially uncontested. Defendant did not dispute the accuracy of these practices or that insurance companies can and do deduct such reserves.

Plaintiffs used the above-mentioned methods to determine that, as of the end of 1972, their liability

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[1] Accruals for Prudential plans were established using a "lag factor" derived by averaging both the number of days of lag for each claim and the amount of each payment. This lag factor was then applied to the total amount of claims paid in the prior period. The Aetna-serviced facilities determined their reserves by (1) taking the reserve balances returned upon the change to self-insurance; (2) adding a monthly provision for additional medical benefits; and (3) subtracting the medical benefit drafts which had been paid by year end. Aetna had developed lag factors based on plaintiffs' specific experience which, when compared to the standard lag factor, revealed a close correlation. As a result, plaintiffs used a standard lag factor derived from Aetna's actuarial studies, adjusted both for inflation and for application to the amount of claims paid in a three-month period.

for medical care received during the last quarter of 1972 was $5,575,289. This amount was carried as a liability on plaintiffs' financial statement as of December 31, 1972. General Dynamics Corporation, on behalf of its subsidiaries, filed a consolidated federal income tax return for the calendar year 1972. Plaintiffs did not deduct the reserves in that year; instead, they filed a claim in 1973 [*sic*] asking for the 1972 accrued expense deduction and a refund of $31,708 plus interest. The deduction was disallowed by the Internal Revenue Service.

DISCUSSION

The issue before the court is whether plaintiffs may properly deduct their employee medical benefit reserves in 1972 in accordance with their accrual method of accounting and the Internal Revenue Code.

There is no dispute that expenses incurred by plaintiffs in connection with the medical benefit plans were deductible as ordinary and necessary business expenses under Section 162(a) of the Internal Revenue Code, Title 26 of the United States Code (hereinafter "the Code"). The issue is the timing of plaintiffs' deduction. The general rule establishing the proper taxable year for taking such deductions for accrual method taxpayers is set forth in Treasury Regulation Section 1.461-1(a)(2): "The taxable year in which *all the events have occurred* which determine *the fact* of the liability[,] and *the amount* thereof can be determined with reasonable accuracy." (Emphasis supplied.) This regulation is an adoption of the "all events" test first formulated by the Supreme Court in *United States v. Anderson*, 269 U.S. 422, 46 S.Ct. 131, 70 L.Ed. 347 (1926). If a taxpayer's liability meets the conditions stated by this test, the deduction must be allowed in accordance with the intent of the

regulation and with the fundamental accounting principle that accrual accounts immediately reflect expenses incurred without regard to the timing of actual payment. *See Dixie Pine Products Co. v. Commissioner*, 320 U.S. 516, 519, 64 S.Ct. 364, 365, 88 L.Ed. 270, 272 (1944) ("a taxpayer who accounts on the accrual basis may, and should, deduct . . . a liability which really accrues in the taxable year.").

Thus, under the "all events" test, the cardinal issue before this court is: By the end of 1972, had all events occurred which established (1) the fact of, and (2) the amount of, plaintiffs' liability for medical treatment received by their employees in 1972?

Fact of Liability

The first prong of the "all events" test requires the taxpayer, seeking to deduct an accrued expense, to demonstrate that the fact of liability was certain at the end of the tax year in question. *Eastman Kodak Company v. United States*, 209 Ct. Cl. 365, 375, 534 F.2d 252, 258 (1976). Plaintiffs assert that their liability is established when a qualified employee or dependent receives covered medical services. At that point, all conditions to basic liability under the self-insured plans are satisfied: (1) the person is eligible for benefits; (2) the services are covered by the plan; and (3) treatment is in fact received. Defendant rejoins that liability is established only after a claim has been received, reviewed, and acted upon by plaintiffs. Defendant avers that until liability is determined by the claims processsor, plaintiffs' obligation to pay benefits is uncertain and therefore, contingent.

The court believes that defendant's emphasis on the claims-processing procedure is misplaced. According to the evidence adduced at trial, the procedure

was routine and clerical. The claims-review process was performed by experienced claims-handling personnel and was a matter of established procedure which included calculating the amount of payment according to clear and objective benefit schedules and formulas set forth in the plans. While the claims-processing procedure is a necessary event in obtaining reimbursement under the plans, it is an administrative step of the type considered by the Supreme Court in *Anderson* not to be a bar to satisfying the first prong of the "all events" test. In *Anderson*, where liability for a munitions tax had already accrued, the event of actual tax assessment in the following year was considered to be "technical" and therefore not necessary to satisfy the "all events" test for the deduction of a tax liability reserve. *Anderson*, 269 U.S. at 441. In the instant case, the events of claim filing and processing similarly are ministerial in nature. As a result, they are not a condition precedent to establishing the fact of liability.

While claims are processed to pay all amounts due under the plans, however, the full amount requested in the claims is not always paid. In such cases, the expense is either of the type expressly excluded or only partially covered by plaintiffs' plan. It has been the experience of the administrators of the final processing that approximately 90% of all submitted claims are paid. Defendant asserts that this 10% variance renders the claims-processing procedure adversarial, and the fact of liability therefore contingent. Contingency, however, connotes contest or uncertainty, neither of which is true in plaintiffs' case. There is little question as to the type and the amount of benefits to which the employees are entitled under the plans. Indeed, plan coverage is clearly

outlined in booklets describing the standards for payment. The fact that 10% of the claims include expenses not covered by the plans does not *ipso facto* make plaintiffs' liability uncertain. To the contrary, such liability is fixed and certain at the time the eligible employee receives covered medical care.

Defendant also maintains that, to the extent an injured employee chooses not to file a claim, or is not eligible for claimed benefits, plaintiffs' liability remains uncertain until after a liability determination is made. These types of uncertainties, however, were not considered to render an employer's liability for worker's compensation benefits contingent in *Kaiser Steel Corp. v. United States*, 717 F.2d 1304 (9th Cir. 1983). Following *Crescent Wharf & Warehouse Co. v. Commissioner*, 518 F.2d 772 (9th Cir. 1975), the court in *Kaiser* held that, under a state worker's compensation statute, once a worker is injured in the course of employment and liability is not contested by the employer, all events establishing the self-insured employer's liability to pay have occurred, thus meeting the first prong of the "all events" test. In the present action, plaintiffs' obligation to pay for medical care arose under the self-insured plans when an eligible employee received covered treatment. Indeed, liability was fixed by contract upon receipt of covered medical services. The logic of *Crescent* and *Kaiser* dictates that the fact of *injury* establishes the fact of *liability*. Therefore, the occurrence of the insured event, i.e. an employee receiving covered medical care, is the critical event giving rise to plaintiffs' obligation to pay. For these reasons, plaintiffs' liability cannot be characterized as contingent.

When plaintiffs calculated their liability and deposited the calculated amount in their accrued ex-

pense reserves, those amounts inured to, and for, the benefit of employees who had received medical care in the last quarter of 1972. Defendant would have the court distinguish plaintiffs' reserves from other types of deductible accrued expense reserves, on the basis of the revocability of funds contributed to such accounts. Thus, defendant argues that because plaintiffs were not irrevocably bound to pay the full amount in the reserves, they are attempting to deduct an estimate of future indebtedness. Defendant cites two cases for the proposition that express provisions to contribute certain irrevocably committed amounts to the deductible liability reserves must appear in the plans under which liability was fixed: *Washington Post Company v. United States*, 186 Ct. Cl. 528, 405 F.2d 1279 (1969) (involving a profit-sharing plan), and *Inland Steel Company v. United States*, 212 Ct. Cl. 558, 566 F.2d 1188 (1976) (concerning supplemental unemployment benefits pursuant to a collective bargaining agreement). Both of these cases are unpersuasive. In *Zwicker Knitting Mills v. United States*, 80-2 U.S.T.C. p. 9832 (Ct. Cl. 1980), the Court of Claims held that it is not the presence of such an express provision in a benefit plan which absolutely fixes liability. Moreover, it held that the fact that unexpended portions of the reserve could have conceivably reverted to corporate use is insignificant. *Id.* Finally, it is clear that only the existence of an absolute liability is necessary for passing the "all events" test; absolute certainty that it will be discharged by payment is not. *Helvering v. Russian Finance Construction Corp.*, 77 F.2d 324, 327 (2d Cir. 1935).

Defendant additionally contends that liability wasn't fixed in 1972 because plaintiffs did not know by year's end the identity of the employees who had

received medical treatment that year. Although plaintiffs' situation is distinguishable from the situation in *Kaiser*, wherein taxpayers had the benefit of a filed claim upon which to base their estimated liability, the distinction is immaterial. Plaintiffs' liability, in the instant case, was not based on the filing of a claim; rather, it was fixed under the terms of the self-insured plans upon occurrence of the insured event—the receipt of covered services by the insureds. Temporary uncertainty as to the identity of the payee, or the time or amount of payment, does not preclude a taxpayer from having a fixed liability for purposes of the "all events" test. Once liability itself is fixed, other uncertainties do not destroy the initial certainty. *See Washington Post Company*, 186 Ct. Cl. at 536, 405 F.2d at 1284.

We find that the last event necessary to fix plaintiffs' liability was the *occurrence* of the insured event. Plaintiffs were not predicting the happening of future events; rather, they were estimating the amount of fixed liability for events which had already occurred. As of year end 1972, the events giving rise to plaintiffs' obligation had occurred, and nothing could change the extent of their liability. Applying the "all events" test to the facts of this case in a reasonable and practical manner demonstrates that plaintiffs satisfy the first prong of the test.[2]

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[2] Plaintiffs do not attempt to deduct their reserves under the sections of the Code applicable to insurance companies. Defendant asserts that the existence of these code sections [§§ 809(d)(1) and 832(b)(5) allowing life and casualty insurers to deduct incurred but unascertained losses] and the repeal of § 462 (a section which had allowed ordinary taxpayers to deduct estimated expense reserves) manifest a clear legislative intent against allowing ordinary taxpayers to accrue and deduct estimated expenses. The court disagrees

Amount of Liability

Although the exact amount of plaintiffs' incurred liability could not have been determined by year end, plaintiffs should have been permitted to accrue such liability in 1972, so long as the amount could be computed with reasonable accuracy. Treasury Regulation § 1.461-1(a)(2) (1984). The cardinal issue is whether the amount of plaintiffs' liability for employees who received medical care in 1972, but which benefits became payable in later years, could be determined with reasonable accuracy through application of plaintiffs' methods.

A comparison of the total amount of medical benefit claims paid in 1973 and 1974 for services received in 1972 ($4,583,893), and the accrued reserve amount sought to be deducted for this liability at year-end 1972 ($5,575,289), indicates that 82.2% of the reserve was subsequently paid. This percentage, i.e., 82.2%, is well within the reasonably accurate range accepted by the courts for the purposes of satisfying the second prong of the "all events" test. *See, e.g., Harrold v. Commissioner* 192 F.2d 1002, 1003 (4th Cir. 1951) (81%), and *Denise Coal Company v. Commissioner*, 271 F.2d 930, 936 (3rd Cir. (48%).

Plaintiffs' witnesses from Prudential and Aetna, accepted by the court to be experts in the field of setting and determining reserves under group medical benefit plans, testified that the methods used by

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with this interpretation of legislative history. We think that the 1954 enactment and 1955 repeal of § 462 operates to reestablish the "all events" test as the appropriate standard for ordinary taxpayers to meet. *See American Automobile Association v. United States*, 367 U.S. 687, 698, 81 S.Ct. 1727, 1733, 6 L.Ed.2d 1109, 1116 (1961) (Stewart, J., dissenting).

plaintiffs were reasonably accurate methods for determining the amount of plaintiffs' liabilities for medical services rendered, but not paid, by December 31, 1972. Defendant, however, claims that the accuracy of plaintiffs' liability reserve should not be measured in the aggregate. Defendant asserts that the "all events" test requires an item-by-item approach to determine individual liability as to each employee. The use of the aggregate method for setting amounts of liability reserves, however, was approved by the court in *Kaiser*, 717 F.2d at 1309. Similarly, no separate liability determination as to individuals was required in *Washington Post*, 186 Ct. Cl. at 535, 405 F.2d at 1283. In 1972, plaintiffs employed approximately 56,000 people, and received thousands of claims for payment of medical services rendered in that year. Requiring plaintiffs to determine the amount of liability on an individual basis would be neither realistic nor in accordance with sound business practice. *See Harrold*, 192 F.2d at 1006. Therefore, we find that plaintiffs' system for determining the *amount* of their liability was logical and reasonable.

CONCLUSION

When all the facts which determine the existence of a taxpayer's liability have occurred in the taxable year, and the amount, although not definitely ascertained, is susceptible to reasonably accurate estimation at the end of that taxable year, a deduction from income may be taken. *Harrold*, 192 F.2d at 1006. Because plaintiffs have established that their liability had arisen by the end of 1972, and that their method of calculating that liability is reasonably accurate, the requested deduction will be allowed pursuant to 26 U.S.C.A. § 162(a) n.21 (1978). Having met the

"all events" test, plaintiffs' are entitled to a refund in the amount of $31,708 plus interest, representing their valid deduction for expenses incurred in 1972. Pursuant to RUSCC 58, the Clerk of the Court is directed to enter judgment in accordance with this opinion.

It is so ORDERED.

/s/ ROBERT M. M. SETO
Judge

APPENDIX C

IN THE UNITED STATES CLAIMS COURT

No. 7-81 T

GENERAL DYNAMICS CORP., a Delaware corp.,
STROMBERG-CARLSON CORP., a Delaware corp.,
DATAGRAPHIX, INC., a Delaware corp.,
MATERIAL SERVICE CORP., a Delaware corp.,
and MARBLEHEAD LIME CO., a Delaware corp.

v.

THE UNITED STATES

Filed Sept. 16, 1984

JUDGMENT

Pursuant to the opinion of September 7, 1984, it was held that plaintiffs are entitled to recover.

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that plaintiffs recover of and from the United States the sum of $31,708 plus interest, representing their valid deduction for expenses incurred in 1972.

FRANK T. PEARTREE
Clerk of Court

By: /s/ Lind A. Eddins
Deputy Clerk

NOTE: As to appeal, 60 days from this date, see FRAP 4(a)

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

No. 85-760
7-81 T

GENERAL DYNAMICS CORP., ET AL., APPELLEES

vs.

THE UNITED STATES, APPELLANTS

JUDGMENT

ON APPEAL from the United States Claims Court.

This CAUSE having been heard and considered, it is

ORDERED and ADJUDGED: Affirmed.
Dated: September 19, 1985

ENTERED BY ORDER OF THE COURT
FRANCIS X. GINDHART,
Clerk

/s/ Francis X. Gindhart
Clerk

Issued as a Mandate: October 11, 1985

APPENDIX E

Internal Revenue Code of 1954 (26 U.S.C.), as amended and as in effect for the years at issue:

SEC. 162. TRADE OR BUSINESS EXPENSES.

(a) *In General.*—There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business * * *

* * * * * *

SEC. 446. GENERAL RULE FOR METHOD OF ACCOUNTING.

(a) *General Rule.*—Taxable income shall be computed under the method of accounting on the basis of which the taxpayer regularly computes his income in keeping his books.

(b) *Exceptions.*—If no method of accounting has been regularly used by the taxpayer, or if the method used does not clearly reflect income, the computation of taxable income shall be made under such method as, in the opinion of the Secretary, does clearly reflect income.

(c) *Permissible Methods.*—Subject to the provisions of subsections (a) and (b), a taxpayer may compute taxable income under any of the following methods of accounting—

(1) the cash receipts and disbursements method;

(2) an accrual method;

(3) any other method permitted by this chapter; or

(4) any combination of the foregoing methods permitted under regulations prescribed by the Secretary.

* * * * *

SEC. 461. GENERAL RULE FOR TAXABLE YEAR OF DEDUCTION.

(a) *General Rule.*—The amount of any deduction or credit allowed by this subtitle shall be taken for the taxable year which is the proper taxable year under the method of accounting used in computing taxable income.

* * * * *

Treasury Regulations on Income Tax (1954 Code) (26 C.F.R.):

§ 1.446-1. *General rule for methods of accounting.*

(a) *General rule.* (1) Section 446(a) provides that taxable income shall be computed under the method of accounting on the basis of which a taxpayer regularly computes his income in keeping his books. The term "method of accounting" includes not only the over-all method of accounting of the taxpayer but also the accounting treatment of any item. Examples of such over-all methods are the cash receipts and disbursements method, an accrual method, combinations of such methods, and combinations of the foregoing with various methods provided for the accounting treatment of special items. These methods of accounting for special items include the accounting treatment prescribed for research and experimental expenditures, soil and water conservation expenditures, depreciation, net op-

erating losses, etc. Except for deviations permitted or required by such special accounting treatment, taxable income shall be computed under the method of accounting on the basis of which the taxpayer regularly computes his income in keeping his books. For requirement respecting the adoption or change of accounting method, see section 446(e) and paragraph (e) of this section.

(2) It is recognized that no uniform method of accounting can be prescribed for all taxpayers. Each taxpayer shall adopt such forms and systems as are, in his judgment, best suited to his needs. However, no method of accounting is acceptable unless, in the opinion of the Commissioner, it clearly reflects income. A method of accounting which reflects the consistent application of generally accepted accounting principles in a particular trade or business in accordance with accepted conditions or practices in that trade or business will ordinarily be regarded as clearly reflecting income, provided all items of gross income and expense are treated consistently from year to year.

* * * * *

(c) *Permissible methods* — (1) *In general.* Subject to the provisions of paragraphs (a) and (b) of this section, a taxpayer may compute his taxable income under any of the following methods of accounting:

(i) *Cash receipts and disbursements method.* Generally, under the cash receipts and disbursements method in the computation of taxable income, all items which constitute gross income

(whether in the form of cash, property, or services) are to be included for the taxable year in which actually or constructively received. Expenditures are to be deducted for the taxable year in which actually made. For rules relating to constructive receipt, see § 1.451-2. For treatment of an expenditure attributable to more than one taxable year, see section 461(a) and paragraph (a)(1) of § 1.461-1.

(ii) *Accrual method.* Generally, under an accrual method, income is to be included for the taxable year when all the events have occurred which fix the right to receive such income and the amount thereof can be determined with reasonable accuracy. Under such a method, deductions are allowable for the taxable year in which all the events have occurred which establish the fact of the liability giving rise to such deduction and the amount thereof can be determined with reasonable accuracy. The method used by the taxpayer in determining when income is to be accounted for will be acceptable if it accords with generally accepted accounting principles, is consistently used by the taxpayer from year to year, and is consistent with the Income Tax Regulations. For example, a taxpayer engaged in a manufacturing business may account for sales of his product when the goods are shipped, when the product is delivered or accepted, or when title to the goods passes to the customer, whether or not billed, depending upon the method regularly employed in keeping his books.

* * * * *

§ 1.461-1 *General rule for taxable year of deduction.*

(a) *General rule.*—

* * * * *

(2) *Taxpayer using an accrual method.* —Under an accrual method of accounting, an expense is deductible for the taxable year in which all the events have occurred which determine the fact of the liability and the amount thereof can be determined with reasonable accuracy. However, any expenditure which results in the creation of an asset having a useful life which extends substantially beyond the close of the taxable year may not be deductible, or may be deductible only in part, for the taxable year in which incurred. While no accrual shall be made in any case in which all of the events have not occurred which fix the liability, the fact that the exact amount of the liability which has been incurred cannot be determined will not prevent the accrual within the taxable year of such part thereof as can be computed with reasonable accuracy. For example, A renders services to B during the taxable year for which A claims $10,000. B admits the liability to A for $5,000 but contests the remainder. B may accrue only $5,000 as an expense for the taxable year in which the services were rendered. In the case of certain contested liabilities in respect of which a taxpayer transfers money or other property to provide for the satisfaction of the contested liability, see § 1.461-2. Where a deduction is properly accrued on the basis

of a computation made with reasonable accuracy and the exact amount is subsequently determined in a later taxable year, the difference, if any, between such amounts shall be taken into account for the later taxable year in which such determination is made.

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No. 85-1385

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

UNITED STATES OF AMERICA,

Petitioner,

v.

GENERAL DYNAMICS CORPORATION, GENERAL DYNAMICS LAND SYSTEMS, INC. (formerly called Stromberg-Carlson Corporation), DATAGRAPHIX, INC., MATERIAL SERVICE CORPORATION and MARBLEHEAD LIME COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether an accrual-basis taxpayer providing medical benefits to employees under uninsured medical benefit plans may deduct in 1972 its liability for medical services received in 1972 by employees but unpaid by the end of the year.

STATEMENT REQUIRED BY RULE 28.1

Respondents have the following affiliated corporations, companies and partnerships: Lachmar Partnership; Mansour-G.D. Ltd.; Mines SNA, Inc./SNA Mines, Inc.; Etudes Techniques et Constructions Aerospatiales, Societe Anonyme; Tusas Aerospace Industries, Inc.; and Continental Cement Company. Respondents have no other parent corporation and no other subsidiary which is not wholly owned.

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IN THE

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OCTOBER TERM, 1985

UNITED STATES OF AMERICA,

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v.

GENERAL DYNAMICS CORPORATION, GENERAL DYNAMICS LAND SYSTEMS, INC. (formerly called Stromberg-Carlson Corporation), DATAGRAPHIX, INC., MATERIAL SERVICE CORPORATION and MARBLEHEAD LIME COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

STATEMENT OF THE CASE

The issue in this case is the proper timing for the deduction by these accrual-basis taxpayers of their liability for medical benefits received by employees.

For many years, taxpayers have provided medical benefits to their employees and their employees' dependents

for non-occupational sickness and injuries. In October, 1972, taxpayers stopped purchasing group health insurance and commenced providing these medical benefits directly. As direct providers of these benefits, taxpayers bore the liability for and paid the medical benefits.

These expenses were clearly deductible; the issue is only one of timing: should the expenses for medical services received by employees in 1972 be deducted in 1972 or a later year. The proper timing for accrual-basis taxpayers was governed by the "all events" test, Treasury Regulation § 1.461-1(a)(2): a liability must be deducted in the year in which all events have occurred which determine the fact of liability.* Payment of an expense by year-end was not required.

In the Claims Court, taxpayers presented substantial evidence showing what the medical benefit plans were and how they operated. In addition to documents and stipulated facts, taxpayers presented three witnesses on this issue: their Director of Employee Benefits, who was in charge of the medical benefit programs from 1970 to 1980; and two medical benefit professionals, each with 23 years of extensive experience in medical claim processing and group medical benefit plan administration. (Tr. 44-46, 70-74; PX 47 at 4-9.)** Taxpayers' evidence was both unrebutted and uncontradicted. Indeed, the government of-

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* The "all events" test has a second element which must also be satisfied: the amount of the liability must be determinable with reasonable accuracy. Both the trial court and the appellate court found that the second element had been met, and the government does not seek review of that issue here. (Petition 13 fn. 2.)

** References are as follows: "App." refers to the Appendix to the Petition for a Writ of Certiorari; "C.A. App." refers to the Appendix in the Federal Circuit; "PX" refers to Plaintiffs' Trial Exhibit; "Tr." refers to the trial transcript. PX 47 was offered and received in evidence at Tr. 42.

fered no witnesses at all. The government's Petition for a Writ of Certiorari completely ignores these witnesses and the substance of this uncontradicted evidence. Instead, the government substitutes its own notions of the nature of the medical benefits, describing them in such a way as to make them appear to be estimates of future contingent liabilities. Of course, ignoring the record is improper, and substitution by the government of its own view of the facts is unwarranted.

After hearing and considering the extensive evidence, the trial court found that taxpayers' liability attached upon the receipt of medical services by their employees and did not await the completion of the routine and clerical processing of the claim forms for payment. (App. 12a-13a, 15a.) Based upon the evidence, this finding was clearly correct.

Specifically, the evidence showed that the plans provided basic medical benefits and major medical benefits. (Tr. 46-47, 78-79; C.A. App. 19; PX 47 at 9-10.) The basic medical benefits included hospital costs (primarily room and board charges), doctors' fees for surgery, costs for anesthesia and other medical services. The basic plan paid 100% of covered items up to specified limits (*e.g.*, $60 per day for a hospital room). The major medical benefits provided for costs exceeding those covered by the basic medical plan, as well as certain additional items (*e.g.*, prescription drugs). The major medical plan had an annual deductible and then paid for costs on a shared basis (*e.g.*, the taxpayers paid 80% and the employees, 20%). Each plan described in detail the persons covered and the exact nature and extent of the benefits provided. (C.A. App 19, 47-73.)

Taxpayers provided these medical benefits to their employees as part of the consideration for the employees'

services. (Tr. 51; C.A. App. 15.) Taxpayers promised their employees that these benefits would be paid. (Tr. 46-47, 51; C.A. App. 15.) Booklets describing the plans were distributed so employees were fully informed of the benefits to which they were entitled. (C.A. App. 19-20; 47-73; Tr. 49-50.) Taxpayers' liability for the medical benefits was a matter of contract; liability did not depend upon any determination of fault or wrongdoing. (C.A. App. 24, 47-73.)

Furthermore, under the plans, taxpayers' general contractual liability to provide benefits became fixed as to particular medical expenses of specific employees at the time the medical services were received by the covered individual. (Tr. 51, 116, 139, 217-218.) At that time, all conditions to the basic liability had occurred: (1) the person receiving the services was covered by the plan, (2) the services were covered by the plan, and (3) the services had been performed. At that time, the employee had a vested right to his benefits.

All witnesses testifying on the subject agreed that under taxpayers' plans, the critical time for fixing of liability for specific benefits was when the services were received, not when claims for payment were filed and processed. Once services had been received, taxpayers could not avoid liability for such services by terminating the plans; claims processed after termination of a plan for services received prior to plan termination would have to be paid. (Tr. 52-53, 117.) Similarly, termination of an employee's employment did not extinguish taxpayers' liability for services received prior to termination, even if the claim form was filed afterwards. (Tr. 51-52, 116-117; PX 47 at 55-56.)

To obtain payment for medical services received, employees submitted claim forms, which underwent a rou-

tine, standardized processing procedure and were paid according to the benefit schedules contained in the plans. (C.A. App. 21; Tr. 53-55, 79-85; PX 47 at 15-20.) Completed forms with supporting documentation, such as doctor's and hospital bills, were submitted. (C.A. App. 21; PX 10, Tr. 33-34, 39-40; Tr. 53-54.) A simple clerical check was made to verify that the person receiving services was covered at the time of treatment. (Tr. 55, 79-80; PX 47 at 15-16.) The forms were then processed by matching the claims against the plans to calculate and pay the amounts due. (Tr. 54-55, 80-85; PX 47 at 16-20, 23; C.A. App. 22.)

The benefit calculations were made expeditiously by experienced claim processors on a large volume basis, pursuant to the provisions and schedules of the plans, augmented by guidelines and routine procedures established by Aetna Life Insurance Company ("Aetna") and The Prudential Insurance Company of America ("Prudential").* (C.A. App. 21, 23; Tr. 76-78, 79-81, 85-87; PX 47 at 14-15, 20-25.) The processors matched the claim data against the detailed provisions of the particular plan. The processors excluded amounts which were not covered at all (such as a hospital meal for a patient's guest and television rental charges on hospital bills), calculated basic medical benefits, and then calculated the major medical benefits.** (Tr. 54,

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* The taxpayers hired Aetna and Prudential to administer the plans when taxpayers took over direct liability for the medical benefits. (C.A. App. 18.)

** In most instances, all necessary data was contained in the papers when the processors received them. In those instances where additional data was necessary, rather than reject the claim, the missing data was obtained, usually by telephone or letter to the employee, doctor or hospital, as the case might be. (Tr. 99-100; PX 47 at 39-41; C.A. App. 21.) Then the processing would be completed.

80-85; PX 47 at 16-23; C.A. App. 22.) This processing was routine and clerical. Approximately 95% of the claims were handled by the regular processors and only 5% required consideration by more experienced supervisors, still in a routine manner. (PX 47 at 24-25; Tr. 85-87.) The witnesses described in detail how specific types of circumstances such as coinsurance (Tr. 104-109; PX 47 at 41-48), preexisting conditions (Tr. 109-112; PX 47 at 36-39), prevailing rates (Tr. 88-93; PX 47 at 33-36), and work-related injuries (Tr. 67-69; PX 47 at 51-52) were handled in routine fashion.

While employees did not receive actual payment for benefits until a claim form was filed and processed, all of the events which determined the fact, as well as the amount, of the liability had occurred prior to the filing of the form. If a claims processor had been at the hospital on the day an employee was discharged, the processor could have processed and calculated the amount of the medical benefit at that time. (Tr. 69, 102-103.)

Disputes regarding medical benefit payments were virtually nonexistent. (Tr. 55-57, 60.) By their very terms, the plans did not purport to pay 100% of all medical costs. (Tr. 47; PX 47 at 50; C.A. App. 47-73.) Employees did not themselves calculate the amount due; instead, they submitted their bills, and the processors made the calculations. Consequently, failure to pay items not covered by the plans did not give rise to a dispute. The philosophy applied in processing the claims was to pay everything which was due. (Tr. 59-60, 102; PX 47 at 56.) Mr. Hawkins, taxpayers' Director of Employee Benefits, testified that he could recall no lawsuits regarding medical benefits in the 10-year period from 1970 to 1980. (Tr. 57.) This was supported by Mr. Schaal of Prudential, who testified that he could recall only two lawsuits regarding taxpayers'

medical benefit plans in the period from 1969 to 1983.* (PX 47 at 53-54.)

SUMMARY OF ARGUMENT

Having failed to offer any evidence to rebut taxpayers' evidence demonstrating that their liability under the medical benefit plans was established by the end of 1972 for all employees who received medical services during 1972, the government properly lost this case in both of the lower courts. On the basis of the uncontradicted evidence and well-established legal standards, the trial court found that the fact-of-liability portion of the "all events" test was clearly satisfied in 1972. Ignoring the evidence and the findings, the government now seeks to conjure up a purported conflict with principles established by this Court and other circuit courts. In fact, no such conflict exists. The lower courts in this case neither departed from settled principles of this Court nor came to conclusions at odds with other circuits. The lower courts merely applied the established law to the proven facts of this case.

The cases cited by the government merely illustrate the well-settled rule that contested liabilities or contingent liabilities (which will arise only upon the occurrence of future events) do not satisfy the "all events" test. For

* This absence of disputes concerning the taxpayers' medical benefit plans was corroborated by the insurance companies' own general experience. Aetna had only 129 lawsuits in 1979 when it made over 16,000,000 claim payments and only 199 lawsuits in 1982 when it made over 33,000,000 claim payments. (Tr. 118-120.) Prudential had 96 lawsuits in 1982 in relation to 450,000,000 claim payments. (PX 47 at 54.)

example, in this case, taxpayers would be precluded by this rule from deducting in 1972 their estimate of the amount of medical benefits they would be required to pay for medical services to be received by employees in 1973. Here, however, the deduction at issue relates to liabilities which had already accrued because of the receipt of medical services by specific employees in 1972. The evidence shows that those liabilities are neither contingent nor contested. The cases starting with *United States* v. *Anderson*, 269 U.S. 422 (1926), which gave birth to the "all events" test, establish that ministerial processing of forms does not delay fixation of liabilities under that test. In short, the evidence and findings establish conclusively that the processing was ministerial, and the well-settled case law establishes that ministerial processing does not preclude a deduction.

Many of the arguments made by the government are irrelevant red herrings. Since the record established that the "all events" test has been satisfied, it is irrelevant what liabilities insurance companies are permitted to deduct or that Congress enacted in 1954, and shortly afterward repealed, a provision allowing taxpayers to deduct certain liabilities that did not satisfy the "all events" test. Also, the fact that certain reserves dictated by prudent accounting principles cannot be deducted if they do not satisfy the "all events" test has no relevance to this case in which the requirements of that test are satisfied.

Finally, this is not a medical benefit test case or a case in which the lower courts have broadly held that all claims for medical benefits are deductible. The lower courts have merely found, quite properly, that the record in this case demonstrates that the deductions at issue here satisfy the well-established criteria of the "all events" test. This case does not merit review by this Court.

ARGUMENT

I. THERE IS NO CONFLICT WITH THE DECISIONS OF THIS COURT.

From the inception of this case, the parties and the courts have agreed that the timing of the deduction for these accrual-basis taxpayers was governed by the "all events" test, which was first enunciated in *United States* v. *Anderson*, 269 U.S. 422 (1926), and was later set out in Treasury Regulation § 1.461-1(a)(2). Under the relevant portion of the test, the taxpayers must deduct a liability when all events have occurred which determine the fact of liability. As a corollary, a deduction is not allowed while a liability is either contingent or contested by the taxpayer. *Brown* v. *Helvering*, 291 U.S. 193 (1934); *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516 (1944).

The cases cited by the government are inapposite to the instant case. For example, *Brown* v. *Helvering*, *supra*, disallowed a proposed deduction for commission refunds which might have to be made by an insurance agent if policies were cancelled in the future. This is a typical situation of a contingent liability which might arise depending upon the occurrence of future events (there, cancellation of policies). In *American Automobile Ass'n* v. *United States*, 367 U.S. 687 (1961), this Court concluded that the taxpayer, an automobile club, could not defer membership income which it had already received on the ground that it would be required to provide services to members upon request over a future period of time. Again, this was a contingent matter dependent upon the occurrence of future events: the events which would cause members to request service had not yet occurred, and the members had, therefore, not requested service. *Dixie Pine*

Products, supra, involved a contested liability, as did *Lucas* v. *American Code Co.*, 280 U.S. 445 (1930), and *Security Flour Mills Co.* v. *Commissioner*, 321 U.S. 281 (1944).

Neither court in this case disagreed with or refused to follow established principles of this Court on this issue. Neither court in this case formulated the applicable law in a fashion which conflicted with established law in opinions of this Court. Neither court in this case held or suggested that contingent or contested liabilities were presently deductible. Instead, based upon the evidence adduced by taxpayers and unrebutted by the government, the trial court found that the events which established the fact of taxpayers' liability (that is, the receipt of medical services by employees) had occurred by the end of 1972, and thus deduction of the liability in 1972 was required. Rejecting the government's argument that the liability in this case was contingent at year-end, the trial court properly found that the liability was fixed and certain. These decisions are clearly consistent with the decisions of this Court.

II. THERE IS NO CONFLICT IN THE DECISIONS AMONG THE CIRCUITS.

A second argument by the government is that the decision of the Federal Circuit below conflicts with three decisions by other circuit courts: *Trinity Construction Co.* v. *United States*, 424 F.2d 302 (5th Cir. 1970), *Bennett Paper Corp.* v. *Commissioner*, 699 F.2d 450 (8th Cir. 1983), and *World Airways, Inc.* v. *Commissioner*, 62 T.C. 786 (1974), *aff'd*, 564 F.2d 886 (9th Cir. 1977). This argument is preposterous since the mere reading of the government's description of these cases in the Petition for a Writ of Certiorari clearly distinguishes them.

Each of these three cases followed the general rule that a liability whose existence is contingent upon the occurrence of an event in the future is not deductible before the contingency occurs. In *Trinity Construction*, an employer was obligated to pay premiums on life insurance policies for certain employees but only if the particular employee was alive when the premium was due. In *Bennett Paper*, a company was obligated to pay bonuses in later years, but only if the employee was still employed when the payment came due. In *World Airways*, the taxpayer had an obligation to perform and pay for overhauls on airplane engines and frames in the future, but only if the airplanes continued in service long enough to log enough flight hours so that the overhaul was in fact due. Furthermore, the taxpayer had contracted with third parties to perform the overhauls, and the taxpayer was only liable to pay for overhauls actually performed.

Obviously, these three cases are totally inapposite to the instant case. In each of these cases, a future event had to happen before any underlying liability came into existence. That is not the case here. Once the employee had been to the doctor and received the medical services, the underlying liability attached. All that remained to be done was the clerical process of calculating the amount of the payment under the terms of the plan. The employee did not have to survive and be living as of the payment date, as in *Trinity Construction*. Nor did he have to continue in taxpayers' employ until payment, as in *Bennett Paper*. The medical services had already been rendered and received by year-end. Taxpayers are not trying to deduct in 1972 an estimate for medical services to be performed in later years, as in *World Airways*.

Thus, the instant case, far from being in conflict with the decisions cited by the government, is in fact in har-

mony with them. Future, contingent liabilities are not presently deductible, while existing and fixed liabilities are. As the trial court found and the appellate court affirmed, the liability for medical services received before the end of 1972 was a current, fixed liability and thus deductible in 1972.

III. THIS CASE DOES NOT MERIT REVIEW BY THIS COURT.

The government argues that this case, because of its supposed broad application in the medical benefits area and beyond, is so important that it requires review by this Court. This is just not so.

This case is apparently the first case to deal directly with a liability for medical benefits. But in reaching their decisions, the courts below relied specifically on the factual record in this case and upon application of well-established case law. Neither court wrote an expansive opinion going beyond the facts of this case. Neither court held that any and all medical benefit plan liabilities are deductible. Neither court held that any and all reserves for unfiled or unprocessed claims are deductible. Neither court held that a reserve for future contingent expenses is deductible. It is just too soon to tell whether this case will have any broad impact.

The government says it has 57 other cases involving similar medical benefit issues. If that is true, the lower courts should evaluate the factual bases of the claims and the respective arguments in more cases before this Court steps into the issue. If, as the government suggests, many claimed deductions for medical benefits do not satisfy the "all events" test, the government will presumably prove that on the record in other cases and either win in the

lower courts or come to this court with a factual record which supports reversal. In any event, the government's Petition for a Writ of Certiorari here is premature. Review at this stage would be ill-advised.

IV. THE DECISIONS BELOW WERE CORRECT.

Whatever surface appeal the government's Petition for a Writ of Certiorari might have comes from its grossly inaccurate presentation of the evidence in the record. The government largely ignores the well-supported findings of the trial court as well as the extensive evidence adduced by taxpayers to show what the medical benefit plans were and how they actually worked. However, the findings are not clearly erroneous and, having been accepted by the two courts below, are not subject to review by this Court. *Berenyi* v. *Director, Immigration*, 385 U.S. 630, 635-36 (1967); see, *Anderson* v. *Bessemer City*, ___ U.S. ___, 84 L. Ed. 2d 518 (1985). The evidence and case law fully support the decisions below.

A. Receipt Of Medical Services By Year-End Fixed Taxpayers' Liability.

Taxpayers clearly satisfied the first part of the "all events" test: the liability for medical services already received but not yet paid was a fixed and definite liability at the end of 1972. The medical benefit plans were in existence and were quite specific regarding who was covered, what was covered, and what would be paid. Prior to receipt of medical services, the plans merely represented potential or contingent contract liabilities. But at the time the employee received the medical services, the facts which established taxpayers' liability occurred: at that time, (a) the employee was or was not covered by

the plan; (b) the medical services were or were not covered; and (c) the medical services were received. Upon receipt of the services, taxpayers' liability had ripened and was contingent no longer. Once the services were received, taxpayers could not avoid liability. Subsequent termination of the plans would not terminate liability for past medical services. If an employee's employment ceased, taxpayers still had to pay for medical services received prior thereto. And the liability existed regardless of whether the claim form had been filed and/or processed before plan termination or termination of employment.

Thus, as the trial court properly held, once the medical services were received, the underlying liability was fixed; the fact of liability was established. (App. 11a-15a.)

B. The Fact That Claims Had To Be Filed And Processed For Payment Did Not Make Taxpayers' Liability Contingent Or Contested.

The government has argued that taxpayers' liability was contingent, potentially available for contest, and not fixed and certain until an employee's claim was filed and fully processed. That argument is contradicted by the trial court's findings, which are correct and certainly not clearly erroneous.

While it is true that claims were not paid until processed, this does not mean that taxpayers were not liable for the purposes of the "all events" test until processing was completed. Liability was not based in any way whatsoever upon fault or wrongdoing by taxpayers; and no adversary was seeking to impose an unwanted liability onto taxpayers. Instead, claims processing was merely a mechanism to calculate the exact amount of a liability taxpayers had already agreed in advance to pay. Claims were

processed by the thousands in a routine, repetitive, systematized, clerical procedure. Based on the evidence presented at trial, the trial court correctly concluded that "defendant's emphasis on the claims-processing procedure is misplaced." (App. 11a.)

While claims processing served a verification function and was the mechanism by which the dollar amounts of the benefit calculations were made, the processing was not a set of "future events" which substantively determined the fact of liability. All of the facts upon which the processors based their calculations had already occurred before the process began. The doctor had been visited, the services had been performed, and the charges for the services could be determined. The processor merely had to match the charges against the plans' benefit schedules. Indeed, if the processor were physically at the doctor's office when the patient left, the calculation of the benefit payment could have been made on the spot.

The Treasury Regulation and relevant cases clearly establish that taxpayers' liability for services received in 1972 was fixed by the end of 1972 and that the filing and processing of claims did not change that result. The seminal case articulating the "all events" test, *United States* v. *Anderson*, 269 U.S. 422 (1926), supports taxpayers' position and was properly relied on by the trial court. (App. 11a-12a.) *Anderson* involved the timing of a deduction for a munitions tax. The tax was based on munitions sold in 1916, but was not assessed, due or payable until 1917. The taxpayer deducted the tax in 1917, but the government asserted that the tax liability accrued before assessment and was deductible in 1916. This Court ruled in favor of the government, stating:

> Only a word need be said with reference to the contention that the tax upon munitions manufactured and

> sold in 1916 did not accrue until 1917. In a technical legal sense it may be argued that a tax does not accrue until it has been assessed and becomes due; but it is also true that in advance of the assessment of a tax, all the events may occur which fix the amount of the tax and determine the liability of the taxpayer to pay it. . . . In the economic and bookkeeping sense with which the statute and Treasury decision were concerned, the taxes had accrued. 269 U.S. at 440-41.

The decision in *Anderson* squarely supports taxpayers' deduction in 1972. Since *Anderson* found that a step as important as assessment of the tax did not defer the deduction, here the filing and processing of the claim is not necessary to satisfy the "all events" test. Relying upon *Anderson*, the trial court correctly held that claims processing was the type of "administrative" or "ministerial" step which does not delay the fixing of liability under the "all events" test. (App. 11a-12a.)

The decisions below are also consistent with this Court's opinion in *Continental Tie & Lumber Co.* v. *United States*, 286 U.S. 290, 295-98 (1932). There a present accrual was held to be required for an award which had not yet been made by the Interstate Commerce Commission (and was therefore yet in an undetermined amount) pursuant to a newly enacted statute. Clearly, claim processing, involving calculations and evaluation, still had to occur before an award was ultimately made. This Court concluded that the Commission's function was ministerial and thus did not preclude accrual.

More recent cases demonstrate that liability may be fixed for the "all events" test even though payment depends upon future events much more significant than the filing of claims and processing of paperwork. In the area of workmen's compensation liability (where state stat-

utes impose liability for occupational injuries to employees with detailed benefit schedules for medical treatment, lost wages and permanent disability payments), courts have found that the taxpayer's liability became fixed for purposes of the "all events" test at the time the employee was injured and before rendition of medical services. *Crescent Wharf & Warehouse Co.* v. *Commissioner*, 518 F.2d 772 (9th Cir. 1975); *Kaiser Steel Corp.* v. *United States*, 717 F.2d 1304 (9th Cir. 1983); *Imperial Colliery Co.* v. *United States*, 599 F.Supp. 653 (S.D.W.Va. 1984).

In the strip mining cases (where by state statute a strip miner had the obligation to backfill and restore the land after mining), the courts have held that the taxpayers' liability attached for the purposes of the "all events" test at the time the mining occurred even though the work to backfill the land would not be performed until a future year. *Harrold* v. *Commissioner*, 192 F.2d 1002 (4th Cir. 1951); *Denise Coal Co.* v. *Commissioner*, 271 F.2d 930, 934-37 (3rd Cir. 1959); *Ohio River Collieries Co.* v. *Commissioner*, 77 T.C. 1369 (1981).

The instant case is a stronger and easier one for a deduction than either the workmen's compensation or strip mining cases, where a deduction was allowed for services to be performed in the future. Here, the medical services have been received by the end of 1972.

In addition to its "contingent claim" argument, the government has suggested that liability cannot exist until processing is complete because there might be some contested claims. This is another position which ignores reality. The fact is that medical benefit claims were not contested. The uncontradicted testimony was that medical benefit claims processing was nonadversarial and did not result in disputes. As the trial court found, claims were

processed to pay the employees all they were due under the plans. (App. 12a.) To the extent medical bills were not paid in full, it was because the plans covered most but not all expenses (*e.g.*, semi-private room costs rather than private room costs). The evidence was that there were only two lawsuits regarding taxpayers' medical benefits in ten years.

Liabilities must actually and affirmatively be disputed to make them contested and thus nondeductible. *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516, 519 (1944). Treasury Regulation § 1.461-2(b)(2) defines "contest" as requiring a "bona fide dispute" and an "affirmative act denying" the liability. (See Addendum.) The trial court properly rejected the government's argument on this point, both factually and legally. (App. 12a-13a.) Indeed, on appeal, the government conceded that these claims were not contested. (Government's Reply Brief p. 6.)

C. Taxpayers' Liability Was Fixed Even Though They Did Not Know All Claimants And Amounts At Year-End.

The government argues that liability is not fixed because taxpayers did not know the precise identity of all the employees who had received medical services by year-end and the amounts of each claim. Of course, taxpayers knew the names of those employees who had submitted forms which were undergoing processing. While taxpayers did not have this knowledge for those employees who had not yet filed claims, this fact is irrelevant.

The liability at issue is not for services to be performed in the future for employees whose identity will be determined by future events. (Tr. 146, 228-229.) Here, the lia-

bility was fixed because at the end of 1972 services had in fact been received by specific, identifiable persons who were members of a fixed group: taxpayers' covered employees and their eligible dependents. Taxpayers did not know all of the names only because they had not collected this information. But since the services had been received, the liabilities to specific people were fixed; their identities were knowable. Taxpayers could have canvassed all of their employees in December of 1972 and ascertained who had claims for medical benefits which had not yet been filed. This clearly satisfies the legal requirements. *Uncasville Mfg. Co.* v. *Commissioner*, 55 F.2d 893, 895 (2d Cir. 1932).

A number of cases have previously established that taxpayers did not need to have a roster of the actual names of all persons receiving medical services in 1972. In each of these cases, the government's arguments that uncertainty as to persons to be paid, time of payment and amount to be paid to each person made liabilities contingent and nondeductible were rejected, even when these facts were not only unknown but unknowable. *Washington Post Co.* v. *United States*, 405 F.2d 1279 (Ct. Cl. 1969) (accrual for liability for amounts due a profit-sharing plan which amounts were not vested for any person); *Lukens Steel Co.* v. *Commissioner*, 442 F.2d 1131 (3d Cir. 1971) (accrual for liability for amounts due in future to supplemental unemployment benefits plan which would pay benefits to workers laid off in the future); *Inland Steel Co.* v. *United States*, 212 Ct. Cl. 558 (1976) (also an accrual for a supplemental unemployment benefit plan).

Contrary to the government's argument, taxpayers in this case are not attempting to deduct future, contingent liabilities based on the excuse that they are able to estimate the amount with reasonable accuracy. They are not seeking to deduct in 1972 the amount of medical expenses

to be incurred in 1973 for services received in 1973 on the theory that they can reasonably estimate what that amount will be. Instead, taxpayers are seeking a deduction in 1972 for existing liabilities for services received in 1972. These services had already been received by specific individual employees. Any additional requirement that taxpayers actually have a roster of the specific names and amounts by year-end is unnecessary to satisfy the "all events" test and would be unreasonable. A deduction should not depend on the size of the taxpayer; yet that would be a result of such a requirement. Taxpayers had approximately 56,000 employees in 1972. (C.A. App. 23-24.) They could have, but did not, collect the names of persons receiving medical services by year-end. That would have been a burdensome expense. But an employer with 100 employees could easily and inexpensively collect such names at year-end and take the deduction according to defendant's position. Such a result is irrational and unjustifiable.

D. Payment Does Not Have To Be Presently Due.

The government really seeks to impose on accrual-basis taxpayers the cash basis of accounting for their expenses. The cases show that, as here, the government is typically arguing that some step must be taken or some fact must yet occur before a deduction is proper. In reality, the government is not satisfied until payment has actually been made or is ready to be made.

But Treasury Regulation § 1.461-1(a)(2) and the cases do not require taxpayers to be on the cash method of accounting for expenses. The decisions of this Court clearly establish that payment does not have to be presently due in order to deduct an existing, fixed and certain liabil-

ity. *United States* v. *Anderson*, 269 U.S. 422, 441 (1926); *American National Co.* v. *United States*, 274 U.S. 99, 105 (1927); *Brown* v. *Helvering*, 291 U.S. 193, 200 (1934).

Thus, the government's argument that there may be a hypothetical employee who waives his benefits by failing to submit a claim form for medical services received is irrelevant. The argument is contrary to this Court's holding in *Anderson*. The possibility in *Anderson* that the munitions tax might never be assessed is at least as great as the possibility that employees might not claim their benefits. Yet this Court treated the argument that the tax did not accrue until assessment as "technical" and disposed of it summarily. Furthermore, this waiver argument would, if accepted, eliminate deduction for any accrued but unpaid expenses. Until actual payment, the recipient could always waive his right no matter how fixed the liability. Consequently, this argument would eliminate completely the accrual basis of accounting for expenses.

* * * * *

The trial court properly held that the taxpayers satisfied the first part of the "all events" test. (App. 15a.) That conclusion was supported by the facts of this case and established case law.

V. THE GOVERNMENT'S RED HERRINGS.

In urging this Court to review this case the government makes arguments about repealed Section 462 of the Internal Revenue Code, special provisions of the Code applicable only to insurance companies, and the distinctions between financial accounting and tax accounting. These arguments are red herrings.

Congress did enact and then repeal Section 462, which allowed ordinary taxpayers to deduct currently certain

general categories of expenses which did not satisfy the "all events" test. But this is irrelevant to the instant case. So long as the present test for deductibility (the "all events" test) is met, a liability must be deducted. Both lower courts properly found that taxpayers' liability met the current test.

It is also true that there are special provisions for deductions of reserves by insurance companies. But again this is irrelevant to this case. Taxpayers did not claim that they were entitled to their deduction because they were de facto insurance companies. Having satisfied the test for deductions by ordinary taxpayers — the "all events" test, taxpayers were entitled to their deduction.

The government also argues that reserves which are prudent for accounting purposes may not meet the requirements for a tax deduction. True, but irrelevant. This deduction is properly based on existing legal standards, not financial accounting rules.

The government's argument on these points boils down to the proposition that if an item can be called a "reserve," it is not deductible, and the government wins. However, this labeling game is phony; the issue is whether the "all events" test is satisfied. In *Anderson*, the seminal "all events" case, this Court held that a "reserve for taxes" was deductible. As the Tax Court has stated:

> "Simply using the term ["reserve"] to describe the deductions in issue is insufficient. . . . Where, as in the current case, the liability in question satisfies both requirements of the all events test, accrual is proper despite the label used by [the government]." *Buckeye International, Inc.* v. *Commissioner*, 49 T.C.M. 376, 385 (1984).

VI. THIS CASE IS NOT GOVERNED BY THE *HUGHES PROPERTIES* CASE.

The government seeks to buttress its request in this case by pointing to the case of *Hughes Properties, Inc.* v. *United States*, 760 F.2d 1292 (Fed. Cir. 1985), which is pending before this Court (No. 85-554) on the issue of deductibility of progressive jackpots on slot machines. In *Hughes*, "progressive jackpots"—jackpots which increase in size as the machine is played—are on slot machines at year-end and are meant to be won by a player in the future.

As conceded by the government, *Hughes* does not control this case. (Petition p. 20.) The slot machine case is clearly distinguishable on many points from the instant medical benefits case.* First, as the government emphasizes in *Hughes*, no player has, in fact, pulled the handle and won the jackpot. The players who played the machine up to the end of the year and who did not win the jackpot have no claim and will never have a claim against the casino. In *Hughes*, the government expresses great concern that at year-end, there is no winning player to enforce the jackpot liability. In the instant case, the employees have already been to the doctor and received services before year-end. Consequently, these people exist to enforce the liability. If their employment is terminated, they still can enforce the liability for medical services received while employed. If the plan is terminated, employees who have already received services can enforce that liability. Secondly, in this case, there is clearly no opportunity for tax manipulation at the discretion of the

* The *Hughes Properties* case was in direct conflict with *Nightingale* v. *United States*, 684 F.2d 611 (9th Cir. 1982). In the instant case, however, there is no conflict among the circuits.

taxpayers. The government expresses concern in *Hughes* that the casino is free to put extra slot machines on the floor at year-end to increase the progressive jackpot liability, and that the casino can set the odds on the machine so it is not likely to pay out for a very long time. Whatever the merit or lack of merit of this argument in *Hughes*, no such manipulative control is available to the taxpayers here. The employees have been to the doctor by year-end, and the medical services which they received are fixed. Clearly, any possible finding of nondeductibility in *Hughes* would not control this case.

CONCLUSION

For the reasons stated above, this case does not merit review by this Court, and a Writ of Certiorari should not be granted.

Respectfully submitted,

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March 20, 1986

ADDENDUM

Treasury Regulation § 1.461-2(b)(2): "Any contest which would prevent accrual of a liability under Section 461(a) shall be considered to be a contest in determining whether the taxpayer satisfies paragraph (a)(1)(i) of this section. A contest arises when there is a bona fide dispute as to the proper evaluation of the law or the facts necessary to determine the existence or correctness of the amount of an asserted liability. It is not necessary to institute suit in a court of law in order to contest an asserted liability. An affirmative act denying the validity or accuracy, or both, of an asserted liability to the person who is asserting such liability, such as including a written protest with payment of the asserted liability, is sufficient to commence a contest. Thus, lodging a protest in accordance with local law is sufficient to contest an asserted liability for taxes. It is not necessary that the affirmative act denying the validity or accuracy, or both, of an asserted liability be in writing if, upon examination of all the facts and circumstances, it can be established to the satisfaction of the Commissioner that a liability has been asserted and contested."

Supreme Court, U.S.
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No. 85-1385

In the Supreme Court of the United States

OCTOBER TERM, 1985

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

REPLY MEMORANDUM FOR THE UNITED STATES

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REPLY MEMORANDUM FOR THE UNITED STATES

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1. We contend in our petition that the decision below conflicts with the decisions of other circuits concerning the proper time for accruing tax deductions. See, *e.g.*, *Bennett Paper Corp.* v. *Commissioner*, 699 F.2d 450 (8th Cir. 1983); *Trinity Construction Co.* v. *United States*, 424 F.2d 302 (5th Cir. 1970). The employer in these cases had a contractual obligation to pay future benefits to or for its employees. Although the employer's liability was in large part determined by the workers' past performance of services, its obligation to make the payments at issue was nevertheless contingent at the close of the tax year because it was conditioned on a future event, such as the employees' being alive, or still being employed, at the relevant future time. The courts in these cases denied the employer a current tax deduction, reasoning that an expense is deductible "only in the taxable year when the obligation to pay it is unconditionally fixed" (*Trinity Construction Co.*, 424 F.2d at 305),

and that a "liability is not fixed until all the conditions for payment are met" (*Bennett Paper Corp.*, 699 F.2d at 453). Although these cases did not involve employer obligations under medical expense reimbursement plans, we argued that they involved "circumstances substantially similar to those here" (Pet. 18) and hence conflicted with the decision below.

Respondent does not seek to distinguish these cases on the ground that they involved different sorts of employer-provided benefits. Respondent tries to distinguish them, rather, on the ground that, "[i]n each of these cases, a future event had to happen before any underlying liability came into existence" (Br. in Opp. 11). Respondent argues that its liability to reimburse its workers was not contingent on any future event, but rather became fixed and unconditional "[o]nce the employee had been to the doctor and received the medical services" (*ibid.*).

Respondent's attempted distinction is based on its assumption that the decision below was correctly decided, an assumption with which we of course disagree. Unlike the court of appeals, we think that respondent's year-end liability *was* contingent on future events, namely, upon (1) an employee's submission of a properly-documented claim for reimbursement and (2) respondent's determination that the claim qualified for payment under the terms of the health plans. As we have argued in *United States* v. *Hughes Properties, Inc.*, No. 85-554, the kind of liability presupposed by the "all events" test is the obligation *to make a payment*. See 85-554 U.S. Br. 13-16; 85-554 Reply Br. 3-5.[1] Respondent's obligation to make a payment to its employees was not unconditionally established by the fact that some of them may have visited a doctor before the close of the tax year—a

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[1]We are supplying respondent's counsel with copies of these briefs.

fact which, as we have emphasized (Pet. 12), respondent assumed and estimated rather than proved. To the contrary, respondent's obligation to pay reimbursement did not arise until those employees who had visited a doctor subsequently (1) filed properly-documented claims for reimbursement and (2) satisfied respondent that the medical services that they had received from the doctor were in fact "covered medical services" qualifying for payment under the plans. It is of course true that an employee's visit to a doctor was a *necessary* condition to his eventual receipt of reimbursement, just as an employee's past performance of services in *Bennett Paper Corp.* was a necessary condition to his eventual receipt of the profit-sharing benefits there involved. An employee's visit to the doctor, however, was not a *sufficient* condition to fix respondent's liability, but was only the first in a series of events — an often time-consuming series — by which uncontestably allowable claims were winnowed from an undifferentiated mass of actual and potential requests for reimbursement. Here, as in *Bennett Paper Corp.* and *Trinity Construction Co.*, further events had to occur after the close of the tax year in order for the employer's inchoate liability under its contract to ripen into the concrete obligation to pay something to someone.

As respondent points out (Br. in Opp. 6-7, 14-15, 17-18, 21), of course, the future events that were required to fix its obligation to make a payment had a fairly good chance of occurring. It was likely that many of respondent's employees who had visited a doctor during 1972 would subsequently file claims for reimbursement. And there was a probability — apparently in the range of 90% (Pet. App. 12a) — that those claims, if filed, would be determined to qualify for some payment. But these facts in no way distinguish this case from the cases with which we believe it conflicts. In *Bennett Paper Corp.*, for example, the employer similarly argued that "the Commissioner should

not have considered the accrued [profit-sharing] contribution contingent" inasmuch as there was only a "*de minimis*" possibility that workers would forfeit their benefits by premature termination from service (699 F.2d at 453). The employer in fact demonstrated that, "[o]ver a five-year period, forfeitures amounted to two-tenths of one percent of the contributions to the plan" (*ibid.*). But the Eighth Circuit rejected the employer's argument, holding that its "liability [was] not fixed until all the conditions for payment were met, including the employee remaining an employee" until the relevant future time (*ibid.*). The court of appeals below, in holding that a substantial probability of incurring a liability to make a payment suffices to justify a deduction under the all events test, went into conflict with these decisions and with the decisions of this Court.

2. Respondent disputes our contention (Pet. 18-20) about the importance of this case, asserting that the Federal Circuit's decision was narrowly confined to its facts and that "[i]t is just too soon to tell whether this case will have any broad impact" (Br. in Opp. 12). Other spokesmen for the business community, however, have taken a rather different view of the decision below. A recent issue of *Forbes* magazine described that decision as a "light on the horizon" illuminating the prospect that corporations at long last may be able to deduct "[p]ayments made to self-insurance reserves" (Saunders, *Light on the Horizon,* Forbes, Mar. 24, 1986, at 120). The article noted that "[t]he IRS zealously pursues anyone who tries to blur the distinction between insurance companies and noninsurance companies" and that the Commissioner had accordingly denied respondent's "right to deduct $5.6 million for a self-insurance reserve for 1972" (*ibid.*). The article noted that respondent in 1972 had "pulled some medical coverage from Aetna and Prudential," had "used the insurers' own methods to calculate what the proper reserve would be," and had "contributed that

amount into a self-insurance reserve, deducting the contribution" as a current expense (*ibid.*). The article noted that Congress in 1954 had briefly enacted a provision[2] that would have "allowed noninsurance companies to deduct self-insurance payments," that this provision was projected to "cost the Treasury nearly $1 billion — $4 billion in today's dollars," and that "[l]awmakers hurried to repeal the legislation retroactively" the very next year (*ibid.*). "Small wonder," the article concluded, "that 'devastating' is what [an IRS spokesman] calls the possibility that the Supreme Court might act to uphold the lower courts or passively do so by refusing to hear the case" (*ibid.*). In view of the nationwide jurisdiction of the Court of Appeals for the Federal Circuit, this assessment by a well-known magazine emphatically corroborates our submission concerning the importance of this case.

3. Respondent devotes the bulk of its brief (Br. in Opp. 13-21) to an elaboration of its contention that the decision below was correctly decided. We think that these contentions are best debated in briefs on the merits.

For these reasons and those set forth in our petition, it is therefore respectfully submitted that the petition for a writ of certiorari should be granted.

CHARLES FRIED
Solicitor General

APRIL 1986

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[2]26 U.S.C. (1952 ed. & Supp. II 1954) 462 (discussed at Pet. 16-17).

No. 85-1385

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

UNITED STATES OF AMERICA,

Petitioner,

v.

GENERAL DYNAMICS CORPORATION, GENERAL DYNAMICS LAND SYSTEMS, INC. (formerly called Stromberg-Carlson Corporation), DATAGRAPHIX, INC., MATERIAL SERVICE CORPORATION and MARBLEHEAD LIME COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

SUPPLEMENTAL MEMORANDUM IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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STATEMENT REQUIRED BY RULE 28.1

Respondents have the following affiliated corporations, companies and partnerships: Lachmar Partnership; Mansour-G.D. Ltd.; Mines SNA, Inc./SNA Mines, Inc.; Etudes Techniques et Constructions Aerospatiales, Societe Anonyme; Tusas Aerospace Industries, Inc.; and Continental Cement Company. Respondents have no other parent corporation and no other subsidiary which is not wholly owned.

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SUPPLEMENTAL MEMORANDUM IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

Respondents submit this supplemental memorandum pursuant to Rule 22.6 of the Rules of this Court.

1. After the filing of respondents' brief in opposition, this Court heard oral argument in *United States v. Hughes Properties, Inc.*, No. 85-554. That case involves the timing of a deduction under the "all events" test for

progressive jackpots which are on slot machines, but have not yet been won, at year-end. At oral argument, the government made several statements which undercut arguments made by the government in the instant case, and, further, which demonstrate that this case will not be affected even if *Hughes Properties* were to be decided adversely to that taxpayer.

2. In *Hughes Properties*, the government argued that no fixed liability existed at year-end because no one had won the jackpot; thus, there was no specific obligee; and there "[was] no one in the world who could [at year-end] assert any possible claim to those funds." (Tr. 11.)* The government further argued that the absence of someone to enforce the jackpot liability in the event of the casino's bankruptcy or termination of business proved the absence of any present, fixed obligation. (Tr. 14-17.) Finally, the government contended that the jackpot on the machine was merely an open offer for which no deductible liability existed until the offer was accepted, that is, until the jackpot was won. (Tr. 20.)

3. The instant case is wholly dissimilar. Here, there is no lack of obligees because employees have accepted the "offer" made in the medical benefits plan by visiting their physicians and receiving covered medical benefits before year-end. The respondents are obligated to pay these employees, and their claims would be enforceable in a bankruptcy proceeding or if the respondents ceased doing business.

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* "Tr." refers to the transcript of the oral argument in *Hughes Properties*.

4. In the courts below, the government objected that respondents did not know the identities of each such employee at year-end, but the government conceded in *Hughes Properties* that knowledge of the identity of the obligees was not required under the "all events" test. (Tr. 11-12.) In *Hughes Properties*, the government also acknowledged that payment does not have to be currently due in order to be deductible (Gov't R. Br., No. 85-554 at 8), and that a deduction must be allowed despite the fact that some future event might relieve a taxpayer from actually paying a presently fixed liability (Tr. 15, 23-24).

5. In view of these concessions, the government is now left to argue that the deduction at issue in the case at bar cannot be allowed solely because claim forms must be filed and processed before payment is actually made. The cases establish that the necessity for the performance of ministerial acts cannot suffice to transform deductible, presently fixed liabilities into non-deductible, contingent liabilities. *United States v. Anderson*, 269 U.S. 422 (1926); *Continental Tie & Lumber Co. v. United States*, 286 U.S. 290 (1932). The facts pertaining to claims processing were fully explored in this case, and both courts below held that the processing was ministerial. (Appendix to Petition for Certiorari at 1a, 11a-12a.) Review by this Court to determine whether the findings of fact of both courts below were clearly erroneous is not warranted.

6. In sum, the case at bar is clearly distinguishable from *Hughes Properties* and could not be affected by any decision which this Court might render in that case if adverse to that taxpayer. In addition, the judgment below in the case at bar is correct and fully comports with this Court's prior decisions.

It is therefore respectfully submitted that the petition for a writ of certiorari should be denied.

Respectfully submitted,

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SUPPLEMENTAL MEMORANDUM FOR THE UNITED STATES

The Solicitor General, on behalf of the United States, submits this supplemental memorandum in support of the petition pursuant to Rule 22.6 of the Rules of this Court.

On June 3, 1986, the Court entered its decision in *United States* v. *Hughes Properties, Inc.*, No. 85-554, holding that a gambling casino reporting its taxes under the accrual method of accounting may accrue as a deduction the jackpot amounts shown at year-end on the face of its progressive slot machines. The Court reasoned that Nevada State Gaming Commission regulations, which forbade the casino from "reducing the indicated payoff without paying the jackpot," operated "as a matter of state law" to fix the casino's liability (slip op. 8). "[T]hese jackpot liabilities were definitely fixed. A part of the machine's intake was to be paid out, that amount was known, and only the exact time of payment and the identity of the winner remained for the future" (slip op. 10).

The situation in the present case is significantly different from that in *Hughes Properties*. As we indicated in our petition (85-1385 Pet. 4-5), respondent in the instant case seeks to accrue as a deduction "estimate[s] of its liability to employees who were assumed to have received medical care during the last three months of 1972, but who had not submitted claims, or whose claims had been submitted but not approved, as of that date." Thus, the employees' submission of claims and demonstration of coverage—preconditions whose satisfaction depended upon the diligence of the affected employees, as well as upon determinations whether the medical procedures were covered by the health plans, whether stipulated maximum charges had been exceeded, and whether the treatment was medically necessary—all stood as potential bars to respondent's liability at the close of the tax year.

Accordingly, we do not believe that the decision in *Hughes Properties* will control the outcome in the instant case, or that it will provide the lower courts with guidance on the important question whether taxpayers may accrue deductions for self-insurance plans based upon estimates from prior experience. We therefore again urge the Court to grant plenary review in the instant case.

Respectfully submitted.

CHARLES FRIED
Solicitor General

JUNE 1986

Supreme Court, U.S.
FILED
SEP 8 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-1385 (6)

In the Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

JOINT APPENDIX

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PETITION FOR A WRIT OF CERTIORARI FILED FEBRUARY 18, 1986
CERTIORARI GRANTED JUNE 16, 1986

181 pp

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* The opinions and judgments of the court of appeals and of the Claims Court are printed in the appendix to the petition for a writ of certiorari and have not been reproduced here.

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

No. 85-760

GENERAL DYNAMICS CORP., ET AL., PLAINTIFFS-APPELLEES

v.

UNITED STATES OF AMERICA, DEFENDANT-APPELLANT

RELEVANT DOCKET ENTRIES

November 23, 1984	1.	Certificate of Interest filed by Plaintiff-Appellee. (ak)
January 11, 1985	2.	Appellant's motion for an extension of time (to and including February 11, 1985) to file its opening brief and appendix, filed. (SD-1/10-M) (ejc) GRANTED: January 17, 1985. (ejc)
January 17, 1985	3.	Appellee's response to appellant's motion for an extension of time to file its brief, filed. (SD-1/14-M) (ejc) (SHOULD CIRCUMSTANCES REQUIRE AN EXTENSION OF TIME FOR APPELLEES TO FILE THEIR BRIEF, A MOTION TO THAT EFFECT WILL HAVE TO BE MADE AT THE APPROPRIATE TIME.) (ejc)

February 7, 1985	4.	Appellant's motion for an extension of time (to and including February 18, 1985) to file its brief and appendix, filed. (SD-2/7-M) (ejc) GRANTED: February 8, 1985. (ejc)
February 19, 1985		BRIEF/SEPARATE APPENDIX FOR APPELLANT, filed. (SD-2/19-M) scg
March 25, 1985	5.	Appellees' motion for an extension of time (to and including May 3, 1985) to file their brief, filed. (SD-3/21-M) (ejc) GRANTED: 3/26/85—No further extensions should be expected. (bam)
March 26, 1985	6.	Appellees' motion for an extension of time to file brief (to & including May 3, 1985), filed. (SD-3/21-M). (bam) GRANTED: 3/28/85. (bam)
April 29, 1985		BRIEF FOR APPELLEE, filed. (dm) (SD 4/26-85 M)
May 8, 1985	7.	Appellant's motion for an extension of time to file reply brief (to & including May 20, 1985), filed. (SD-5/7-M). (bam) GRANTED: May 13, 1985. (ejc)
May 8, 1985		*Letter to counsel re oral argument on June 5/6. df*
May 21, 1985		REPLY BRIEF FOR APPELLANT, filed. (SD-5/20-M) (ejc)

June 4, 1985	8.	Appellee's citation of add'l authority, received. (Circulated to panel 6/4/85) (ejc)
June 5, 1985		ARGUED BEFORE FRIEDMAN, RICH, BISSELL. (AMM)
September 19, 1985		AFFIRMED. Bissell, J. (U) ak
October 11, 1985		MANDATE ISSUED TO THE CLAIMS COURT. (rs)
Dec. 12, 1986 [*sic*]	9.	Extension of time granted by Chief Justice on Dec. 10, 1985, to the appellant, to & including Feb. 16, 1986, within which to file its writ of certiorari in the Supreme Court. (scg) (A-446)
Feb. 18, 1986		PETITION FOR CERTIORARI FILED IN THE SUPREME COURT. (85-1385) scg GRANTED: 6-16-86. mym
July 18, 1986	10.	Letter from S.Ct. requesting record be transmitted, received. df
July 22, 1986		Copy of CAFC docket entries, opinion of 9/19/85 and appendix filed 2/2/86 certified and hand delivered to S.Ct. (df)

UNITED STATES CLAIMS COURT

No. 7-81T

GENERAL DYNAMICS CORP., ET AL.,

v.

UNITED STATES OF AMERICA,

RELEVANT DOCKET ENTRIES

Jan. 2, 1981	Filing fee of $10 paid by plaintiffs.
Feb. 5, 1981	Notice of reference to Trial Judge Robert M. M. Seto filed. Copy to parties.
Mar. 9, 1981	Defendant's motion for extension of time (to April 8, 1981) to file answer, etc. filed. Copies (2) to atty. ALLOWED: MAR 11 1981.
Apr. 8, 1981	Defendant's motion for extension of time (to May 8, 1981) to file it answer, etc. filed. Copies (2) to atty. ALLOWED: APR 13 1981.
May 8, 1981	Defendant's answer filed. Copies (5) to atty.
Feb. 22, 1982	Trial Judge's standard pretrial order on liability (Rule 111) filed. Copy to parties. [Submission: April 23, 1982]
Apr. 12, 1982	Plaintiff's motion for extension of time (to May 23, 1982) to comply with pretrial order filed. Copies (2) to deft. ALLOWED: APR 13 1982 with no further

	extension to be granted except for extraordinary circumstances.
Jun 23, 1982	Defendant's motion for extension of time (to August 22, 1982) to comply with pretrial order filed. Copies (2) to atty. ALLOWED: JUN 24 1982
Aug. 23, 1982	Defendant's motion for extension of time (to OCT 21 1982) to file pretrial submission filed. Copies (2) to atty. ALLOWED: SEP 9 1982
Oct. 21, 1982	Defendant's motion for extension of time (to December 20, 1982) to comply with pretrial order filed. Service by mail: 10/21/82. ALLOWED: NOV 10 1982, with no further extensions.
Feb. 16, 1983	Order entered scheduling trial date. Copy to parties.
Jul 20, 1983	Plaintiffs' motion for substitution of attorney of record [from Herbert B. Olfson (who consents) to Lynne E. McNown] filed. Service by mail: 7/18/83.
Aug. 15, 1983	Plaintiffs' motion for ruling on procedural matters filed. Service by mail: 8/9/83. ALLOWED: SEP 6 1983.
Aug. 26, 1983	Defendant's response to plaintiff's motion for ruling on procedural matters filed. Service by mail: 8/26/83.
Sep. 1, 1983	Plaintiffs' clarification of its motion for ruling on procedural matter filed [by leave of the judge]. Service: 8/26/83.
Sep. 8, 1983	Stipulation of facts filed by pltf.
Sep. 20, 1983	Plaintiffs' trial memorandum filed [by leave of the Judge]. Service: 9/8/83.

Sep. 28, 1983	Judge's post-trial order filed. Copy to parties. [Pltf.'s principal brief due: 30 days after filing of transcript—30—20. (Proposed findings of fact and objections shall not be counted in determining length of briefs under Rule 83.1(b)).]
Oct. 17, 1983	Transcript of proceedings (3 volumes) taken at St. Louis, Missouri, on September 12 through 14, 1983; together with plaintiff's exhibits 1 through 47; and defendant's exhibits 1 through 12, and 15 through 21, filed. Notice to parties.
Nov. 3, 1983	Plaintiff's motion for leave to exceed page limitation (by 5 pages filed. Service by mail: 11/3/83. ALLOWED BY ORDER OF JAN 16, 1984
Nov. 16, 1983	Plaintiffs' proposed findings of fact and post-trial brief [two separate documents] filed. Service by mail: NOV 16 1983.
Dec. 15, 1983	Defendant's proposed findings of fact, conclusions of law, and objections to plaintiffs' proposed findings of fact and conclusion of law filed. Service by mail: 12/15/83.
Dec. 15, 1983	Defendant's brief filed. Service by mail: 12/15/83.
Jan. 6, 1984	Plaintiffs' objections to defendant's proposed findings of fact and conclusions of law filed. Service by mail: 1/6/84.
Jan. 6, 1984	Plaintiffs' reply brief filed. Service by mail: 1/6/84.

Jan. 16, 1984	Judge's order re page limitation filed. Copy to parties.
Sep. 7, 1984	Judge's opinion filed. Copies to parties.
Sep. 10, 1984	Judgment entered that plaintiffs recover the sum of $31,708 plus interest, representing their valid deduction for expenses incurred in 1972. Copy to parties.
Sep. 11, 1984	Certified transcript of judgment forwarded to attorney of record. See correspondence in file.
Nov. 9, 1984	Defendant's notice of appeal filed. Copy to plaintiff and C.A.F.C.

IN THE
UNITED STATES COURT OF CLAIMS

No. 7-81T

GENERAL DYNAMICS CORPORATION, A DELAWARE CORPORATION, STROMBERG-CARLSON CORPORATION, A DELAWARE CORPORATION, DATAGRAPHIX, INC., A DELAWARE CORPORATION, MATERIAL SERVICE CORPORATION, A DELAWARE CORPORATION, AND MARBLEHEAD LIME COMPANY, A DELAWARE CORPORATION, PLAINTIFFS

v.

UNITED STATES OF AMERICA, DEFENDANT

PETITION

[Filed Jan. 8, 1981]

The plaintiffs hereby petition for a refund of taxes paid by them for the year 1972 and as the basis of their claim state as follows:

1. Plaintiff General Dynamics Corporation is a Delaware corporation with its principal office in St. Louis, Missouri.

2. Plaintiff Stromberg-Carlson Corporation is a Delaware corporation with its principal office in Tampa, Florida.

3. Plaintiff DatagraphiX, Inc. is a Delaware corporation with its principal office in San Diego, California.

4. Plaintiff Material Service Corporation is a Delaware corporation with its principal office in Chicago, Illinois.

5. Plaintiff Marblehead Lime Company is a Delaware corporation with its principal office in Chicago, Illinois.

6. Defendant is the United States of America.

7. This action arises under the Internal Revenue Code of 1954. The jurisdiction of this Court is based upon 28 U.S.C. § 1491.

8. In 1972, plaintiffs Stromberg-Carlson Corporation, DatagraphiX, Inc., and Material Service Corporation were, and they still are, wholly owned subsidiaries of plaintiff General Dynamics Corporation. In 1972, plaintiff Marblehead Lime Company was, and it still is, a wholly owned subsidiary of plaintiff Material Service Corporation. In 1972, Freeman Coal Mining Corporation ("Freeman"), an Illinois corporation, and The United Electric Coal Companies ("United"), a Delaware corporation, were wholly owned subsidiaries of Material Service Corporation. After 1972, Freeman and United were merged into Material Service Corporation.

9. For the calendar year 1972, plaintiffs, Freeman and United (collectively referred to herein as "taxpayers") filed a consolidated income tax return.

10. The taxpayers use the accrual method of accounting. As accrual basis taxpayers, under § 461(a) of the Internal Revenue Code of 1954 and § 1.461-1(a)(2) of the regulations promulgated under the Code, the taxpayers deduct expenses, not when actually paid, but rather in the taxable year in which all the events have occurred which determine the fact of the liability and the amount thereof can be determined with reasonable accuracy.

11. Beginning in October 1972, the taxpayers became self-insurers under plans of medical care benefits provided their employees and the employees' dependents. The benefits vary by location, but essentially cover hospitalization, surgery, dental and major medical costs. Employees at each location are furnished a booklet or other information describing the benefits available. The program is ad-

ministered by Aetna Life Insurance Company ("Aetna") and the Prudential Insurance Company of America ("Prudential"). These companies formerly insured the program, the premiums for which the taxpayers deducted under their accrual method of accounting.

12. There is a lag between the time medical treatment, such as for hospitalization or surgery, is received by an employee or his dependent and the time the employee's costs for the medical treatment are paid by the taxpayers. When an employee receives medical treatment covered by one of the plans, he submits a health expense benefit claim form. The claims are checked to verify employment and coverage, processed, and paid according to the published benefit schedule.

13. For 1972 and subsequent years, the taxpayers established accrual/reserve accounts to reflect the taxpayers' liability for medical services rendered to employees and their dependents during the year but unpaid at year-end. The amount of the accrual/reserve accounts are determined by taking a percentage, which is supplied by Aetna and Prudential, of the payments made by the taxpayers in a prior period. The percentages are based on the weighted average lag in time in the prior period between incurral of the medical services and payment by the taxpayers. The determination of the amount of the accrual/reserve accounts is made substantially as follows:

1) Number of days between date of incurral of medical services and date of payment by taxpayers	=	Days Time Lag
2) Amount of each payment multiplied by Days Time Lag	=	Weighted Lag
3) Weighted Lag divided by total payments	=	Weighted Average Day Lag Per Payment
4) Weighted Average Day Lag Per Payment divided by total days in period	=	Percentage of Period Lag Per Payment

5) Percentage of Period Lag = Total accrual/reserve Per Payment multiplied by total payments in prior period

This method can be illustrated as follows:

	Payments		Days Time Lag		Weighted Lag	
1)	$ 50	×	30	=	1,500	
	100	×	60	=	6,000	
	50	×	10	=	500	
	$ 200				8,000	
2)	8,000	=	40			
	200					
3)	40	=	10.96%			
	365					
4)	10.96%	×	$200	=	$21.92	Total accrual/ reserve

14. At December 31, 1972, the taxpayers' accrual/reserve accounts for medical services included the amount of $5,601,689 which was the taxpayers' reasonable determination of the amount of their liability for medical treatment provided their employees and the employees' dependents during the year which had not been paid by the end of the year. During 1973 and 1974, the taxpayers actually paid 87.9% of this amount for medical services rendered to their employees and the employees' dependents in 1972.

15. Under the taxpayers' medical care benefit plans, the taxpayers were liable to pay medical care benefit payments when the following three events had occurred: (A) the employee was covered by a medical care benefit plan, (B) the employee or his dependent had received medical services, and (C) those services were included in the plan of benefits available under the medical care benefit plan. The last event to occur which determined the fact of the taxpayers' liability was the rendition of the medical services.

16. The 1972 year-end accrual of $5,601,689 was only for medical services which had been rendered in 1972; no part of that accrual was for medical services to be rendered in a future year. The amount of the accrual was determined with reasonable accuracy based upon the taxpayers' past experience. The taxpayers were entitled to deduct the amount of $5,601,689 for medical treatment provided to the taxpayers' employees and their dependents during 1972 which had not been paid, since all of the events which determined the fact of liability had occurred in 1972 and the amount of that liability was determined with reasonable accuracy. Failure to allow a deduction for the accrual of this liability in 1972 and postponement of the deduction to the years subsequent to 1972 in which the liability was paid would distort the taxpayers' income for 1972 and would make these accrual basis taxpayers operate on cash basis accounting principles in regard to these expenses.

17. On or about September 15, 1973, the plaintiffs timely filed their consolidated income tax return for 1972. The plaintiffs did not deduct the $5,601,689 on that return. All income taxes due for 1972 have been paid.

18. On or about February 22, 1977, the plaintiffs filed a timely and proper claim for refund for 1972 with the Internal Revenue Service, which was amended on or about September 21, 1978, claiming, *inter alia,* a deduction for the $5,601,689 and a refund of $31,708 plus interest.

19. On or about January 26, 1979, the plaintiffs executed Form 3363 (Acceptance of Proposed Disallowance of Claim for Refund or Credit) and Form 2297 (Waiver of Statutory Notification of Claim Disallowance) in respect of their claim for refund for 1972.

20. The deduction of $5,601,689 is proper and should have been allowed. By reason of the plaintiffs' failure to deduct the $5,601,689 on their original 1972 tax return, the plaintiffs have in fact paid more than the proper amount

of income tax due for 1972. After adjustments (including an offset for the recognition of substantial additional income under various long-term contracts as a result of the additional deductible expenses), the tax refund resulting from the deduction of $5,601,689 is $32,001.

WHEREFORE, the plaintiffs pray that this Court:

1. Enter judgment in favor of plaintiffs for $31,708 plus interest as provided by law. .

2. Grant such other or further relief as may be appropriate.

GENERAL DYNAMICS CORPORATION
STROMBERG-CARLSON CORPORATION
DATAGRAPHIX, INC.
MATERIAL SERVICE CORPORATION
MARBLEHEAD LIME COMPANY

By _____

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IN THE UNITED STATES COURT OF CLAIMS

No. 7-81 T

GENERAL DYNAMICS CORPORATION, ET AL., PLAINTIFF

v.

THE UNITED STATES, DEFENDANT

ANSWER

[Filed May 8, 1981]

For its answer to the petition, defendant respectfully denies each and every allegation contained therein, not admitted, qualified, or expressly referred to below:

Defendant further:

1-7. Admits the allegations contained in paragraphs 1 through 7.

8-9. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraphs 8 and 9.

10. Admits the allegations contained in paragraph 10, but states that Section 461(a) of the Internal Revenue Code and the regulations thereunder speak for themselves.

11. Admits the allegations contained in paragraph 11.

12. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph 12.

13. Admits the allegations contained in the first sentence of paragraph 13, but states that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in the remainder of this paragraph.

14-15. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraphs 14 and 15.

16. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in the first sentence of paragraph 16, but denies the allegations contained in the remainder of this paragraph.

17. Admits the allegations contained in paragraph 17.

18. Admits the allegations contained in paragraph 18, but denies that this amended claim for refund claimed a "proper" deduction.

19. Admits the allegations contained in paragraph 19.

20. Denies the allegations contained in paragraph 20.

WHEREFORE, defendant prays that the petition be dismissed with allowable costs assessed against plaintiff.

Respectfully submitted,

/s/ JOHN F. MURRAY
John F. Murray
Acting Assistant Attorney General

/s/ MARC LEVEY
Marc Levey
Attorney

IN THE UNITED STATES CLAIMS COURT

No. 7-81T

GENERAL DYNAMICS CORPORATION, ET AL., PLAINTIFF

v.

THE UNITED STATES, DEFENDANT

STIPULATION OF FACTS

[Filed Sep. 8, 1983]

Plaintiffs General Dynamics Corporation, Stromberg-Carlson Corporation, DatagraphiX, Inc., Material Services Corporation and Marblehead Lime Company, by their attorney, and defendant United States, by its attorney, stipulate for the purposes of this proceeding that the following statements of fact are true and correct.

As used herein, "taxpayers" shall refer to the plaintiffs, Freeman Coal Mining Corporation and The United Electric Coal Companies; "Prudential" shall refer to The Prudential Insurance Company of America; and "Aetna" shall refer to the Aetna Life Insurance Company.

1. Plaintiff General Dynamics Corporation is, and at all relevant times has been, a Delaware corporation with its principal office in St. Louis, Missouri.

2. Plaintiff Stromberg-Carlson Corporation is, and at all relevant times has been, a Delaware corporation. Its principal office was in Rochester, New York in 1972, and now is in Orlando, Florida.

3. Plaintiff DatagraphiX, Inc. is, and at all relevant times has been, a Delaware corporation with its principal office in San Diego, California.

4. Plaintiff Material Service Corporation is, and at all

relevant times has been, a Delaware corporation with its principal office in Chicago, Illinois.

5. Plaintiff Marblehead Lime Company is, and at all relevant times has been, a Delaware corporation with its principal office in Chicago, Illinois.

6. In 1972, plaintiffs Stromberg-Carlson Corporation, DatagraphiX, Inc. and Material Service Corporation were, and they still are, wholly owned subsidiaries of plaintiff General Dynamics Corporation. In 1972, Marblehead Lime Company was, and it still is, a wholly owned subsidiary of plaintiff Material Service Corporation. In 1972, Freeman Coal Mining Corporation ("Freeman"), an Illinois corporation, and The United Electric Coal Companies ("United"), a Delaware corporation, were wholly owned subsidiaries of Material Service Corporation. After 1972, Freeman and United were merged into Material Service Corporation.

7. For the calendar year 1972, plaintiffs, Freeman and United (separately referred to herein as "taxpayer" or collectively as "taxpayers") filed a consolidated federal income tax return.

8. In 1972, the taxpayers used the accrual method of accounting. As accrual basis taxpayers, the taxpayers deducted expenses, not when actually paid, but rather in the taxable year in which all the events had occurred which determined the fact of the liability and the amount of the liability could be determined with reasonable accuracy.

9. In 1972 and for many years prior thereto and for all of the years since then, the taxpayers had established plans pursuant to which they provided extensive medical care benefits for non-occupational sickness or injury (referred to herein as "medical care benefits") to their employees and the employees' qualified dependents. These medical care benefit programs were provided as part of the consideration paid by the taxpayers for their employees' services; these programs were fringe benefits which employees received along with wages and other benefits for their labor.

10. Under the self-insured medical care benefit plans, as part of the terms and conditions of employment of those employees specified as eligible in the plans, the taxpayer promised to pay for the medical care treatment specified in the applicable plan which was received by the employee or the employee's qualified dependent while the employee was employed, according to the benefit schedules stated in the applicable plan.

11. The cost of providing these medical care benefits to their employees were ordinary and necessary business expenses of the taxpayers.

12. For the years prior to 1972 and for most of 1972, the taxpayers provided the medical care benefits by purchasing group medical insurance for the employees and their qualified dependents. For at least ten years up through 1972, this insurance coverage was purchased from two insurance companies: Aetna Life Insurance Company ("Aetna") and The Prudential Insurance Company of America ("Prudential").

13. Aetna basically handled the insurance coverage for the medical care benefits for certain facilities of General Dynamics Corporation (Convair—San Diego, Convair—Ft. Worth, Electronics—San Diego and Dynatronics, and Pomona), for certain facilities of Stromberg-Carlson Corporation (Ardmore, Sanford and Camden) and for Stromberg DatagraphiX, Inc.

14. Prudential basically handled the insurance coverage for the medical care benefits for certain facilities of General Dynamics Corporation (Corporate Office, Electric Boat, Electro Dynamic/Avenel, Electronics—Rochester, and Quincy), for certain facilities of Stromberg-Carlson Corporation (Rochester and Charlottesville), and for Material Service Corporation, Marblehead Lime Company, Freeman and United.

15. The taxpayers were charged premiums for the medical care benefit insurance purchased from Aetna and Pru-

dential. Those premiums were deducted as expenses on the taxpayers' consolidated federal income tax returns. The premiums charged by the insurance companies included amounts for medical services which had been rendered in the policy year but for which claims had not yet been paid.

16. In the latter part of 1972, the taxpayers became self-insurers of their medical care benefit plans. Except for the Fort Worth and the Electric Boat facilities of General Dynamics Corporation, the change to self-insurance was effective on October 1, 1972. The Fort Worth and Electric Boat facilities changed to self-insurance for the medical care benefit plans effective on December 1, 1972.

17. The change to self-insurance in 1972 did not cause a change in the medical care benefits being provided by the taxpayers to their employees. The change to self-insurance merely terminated the insurance coverage for these benefits which the taxpayers had previously obtained from Aetna and Prudential. Effective with the change to self-insurance, the taxpayers (and not Aetna and Prudential) were liable for the costs of providing the medical care benefits.

18. Plaintiffs' Exhibit 1 is a true and correct copy of an Agreement between General Dynamics Corporation and Prudential, which was signed in October, 1972.

19. Plaintiffs' Exhibit 2 is a true and correct copy of an Agreement between General Dynamics Corporation and Prudential, dated December 1, 1972.

20. Plaintiffs' Exhibit 3 is a true and correct copy of the Reserve Refund Agreement between General Dynamics Corporation and Aetna, dated in September, 1972.

21. The taxpayers hired Aetna and Prudential to administer the self-insured medical care benefit plans. Each insurance company continued to service the facilities of the taxpayers for which it had previously provided insurance coverage for the medical care benefit plans.

22. Plaintiffs' Exhibit 4 is a true and correct copy of the

Administrative Services Agreement between General Dynamics Corporation and Prudential, effective October 1, 1972.

23. Plaintiffs' Exhibit 5 is a true and correct copy of the Administrative Services Contract between General Dynamics Corporation and Aetna, effective October 1, 1972.

24. Aetna and Prudential have administered the self-insured medical care benefits plans for the taxpayers from October 1, 1972 to date.

25. Each taxpayer notified its employees of the change to self-insurance by the taxpayer for the medical care benefits.

26. Plaintiffs' Exhibit 6 and Plaintiffs' Exhibit 7 are true and correct copies of announcement letters of the change to self-insurance which were distributed around October and December, 1972, respectively, to General Dynamics Corporation employees whose medical care benefits had been insured by Prudential. Plaintiff's Exhibit 8 is a true and correct copy of a letter dated November 27, 1972, which was sent on or about that date by D. C. Wilkens, Jr., Director of Industrial Relations of the Electric Boat Division of General Dynamics Corporation, to Herbert S. Searle, President of the Marine Draftsmen's Association.

27. In 1972, the medical care benefits provided by the taxpayers under the plans varied somewhat by facility but essentially covered hospitalization, surgery, dental and major medical costs incurred by an employee or his qualified dependent during the time that the employee was employed by a taxpayer.

28. Each self-insured medical care benefit plan described the employees and the dependents covered by the plan. Each plan described the nature and extent of the benefits provided under the plan, including a description of the services and the supplies and amounts which would be paid.

29. Employees at each facility of the taxpayers were furnished a booklet which summarized the provisions of the plan and the benefits which were covered under the plan for that particular facility. These booklets were periodically revised or supplemented to set forth changes in plan provisions and benefits.

30. Plaintiffs' Exhibit 9 is a true and correct copy of the portion of the employee booklet setting forth the medical care benefit plan in effect in December, 1972 (after the change to self insurance), at the Electric Boat facility of General Dynamics Corporation for certain union employees (*i.e.*, those represented by the Patternmakers Association of New London, Connecticut), which booklet was distributed to the appropriate employees around December, 1972.

31. Plaintiffs' Exhibit 40 is a true and correct copy of a portion of the employee booklet setting forth the medical care benefit plan in effect in October, 1972 (after the change to self insurance), at the Ardmore facility of Stromberg-Carlson Corporation for salaried employees, which booklet was distributed to the appropriate employees around October, 1972.

32. The plans of medical care benefits set forth in Plaintiffs' Exhibits 9 and 40 are typical of the plans which were in effect at that time at the other facilities of the taxpayers.

33. Under the self-insured plans, the taxpayers were required to pay for those medical services described in the plan which were rendered to covered employees and qualified dependents. If a covered employee's employment were terminated after the rendition of covered medical services to the employee or a qualified dependent, the employee retained the rights which he had under the plan that the taxpayer pay for those services even if a claim for payment had not been filed before such termination of employment. Similarly, if medical services were received by a qualified dependent and the claim was not filed until after

the dependent ceased to be a qualified dependent, the employee retained his rights under the plan to require payment for those medical services.

34. When an employee or his qualified dependent had received medical treatment covered by a plan, the employee obtained payment for the medical services rendered by filling out and submitting a health expense benefits claim form. These forms underwent a regular processing procedure and were paid according to the terms of the particular plan.

35. Plaintiffs' Exhibit 10 is a true and correct copy of the type of claim form used by the taxpayers in the early 1970's in connection with the medical care benefits plans. The claim form contained pertinent information about the employee and, if applicable, the dependent. It stated necessary information regarding the treatment and services received, including the dates for each medical service or expense, and the cost. Itemized bills were submitted with the claim form.

36. The completed claim forms were submitted to appropriate industrial relations personnel at each facility. The forms were checked against personnel records to verify that the employee or dependent was covered by the particular plan at the time of the treatment. The form was also checked for completeness. If additional information was necessary, it was requested. If the claim was ineligible because the employee or dependent was not covered by the plan at the time of treatment, the processing would stop and the employee would be informed that the claim was not eligible. Such ineligible claims were not sent on to Aetna or Prudential.

37. Eligible claims were then processed further and paid according to the terms of the plans, either by reimbursing the employee or by paying the service provider (such as a hospital) directly.

38. Claims from the taxpayers' facilities administered by

Aetna were sent to the appropriate Aetna claims office for further processing and payment. In these claims offices, Aetna had a staff of claims handlers who were qualified and experienced in the handling of medical care benefit claims. Typically, certain individuals in an Aetna claims office would be familiar with the taxpayers' medical care benefits plans and would handle the processing of the claims submitted by the taxpayers' employees. The Aetna claims personnel calculated the amount of the benefit payments according to the schedules and formulas set forth in the plans.

39. Eligible claims at the taxpayers' facilities administered by Prudential, which facilities did not process their own claims, were sent to Prudential for final processing. Prudential had a staff of claims handlers who were experienced and qualified to process medical care benefit claims. The Prudential claims personnel calculated the amount of the benefit payments according to the schedules and formulas set forth in the plans.

40. At its Quincy and Electric Boat facilities, General Dynamics Corporation had its own staff of experienced, qualified claims personnel who completed the processing and calculated the benefit payments. Prudential's personnel consulted with the Quincy and Electric Boat claims personnel on claims whenever such consultation was needed. Prudential periodically visited these facilities and audited the claims handling performed by the Quincy and Electric Boat facility personnel to determine that claims were being handled properly under the applicable plans.

41. To pay claims, Aetna issued drafts on one of its accounts at the Hartford National Bank. An automatic transfer of funds was made each day from a General Dynamics Corporation account to the Aetna account to cover the drafts cleared through the Aetna account that day. For the facilities administered by Prudential, claims were paid by issuing General Dynamics Corporation drafts.

42. In 1972, The taxpayers had approximately 56,000 employees in the aggregate. Thousands of claims were filed by the taxpayers' employees for payment for medical services, which services had been rendered in 1972. The claims handling process, whether handled by Aetna, Prudential or General Dynamics Corporation, was performed by experienced claims-handling personnel; the process was a matter of established procedures. The plans specified the benefits which were payable. For many items, the plan had a specific dollar amount which was paid. For example, surgical procedures were listed in considerable detail with the specific allowable dollar amounts specified. When a plan provided for a semiprivate room, the claims personnel had current data on the rates for such rooms at hospitals in the area. The major medical benefits were the subject of a set formula.

43. The taxpayers' obligation to pay according to the terms of the plans for the medical care benefits received by covered employees and their qualified dependents was a matter of contract between the employees and taxpayers. The taxpayers' obligation to pay for medical care benefits did not rest upon any determination of fault or wrongdoing.

44. The taxpyers' experience under the self-insured plans has been that, except for rare instances, employees did not contest the disposition of their medical care benefit claims. An explanation of the calculation of a benefit payment is furnished to each employee, giving reasons for amounts which are not covered and thus are not paid.

45. Employees did on occasion have questions pertaining to the benefit calculations and the payments made, but almost all of these questions were resolved by rechecking the calculation and explaining the coverage of the particular plan. In those instances when an employee raised a matter of substance regarding the benefit calculation, the appropriate personnel at the taxpayers, Aetna or Pruden-

tial reviewed the matter further and made a final decision which would conclude the matter except in an extremely small number of instances.

46. There was a lag between the time that the medical services were rendered to an employee or his dependent and the time the employee's costs for the services were paid by the taxpayers. At December 31, 1972, taxpayers had not received all of the claim forms which they would receive for medical treatment services rendered in 1972 to covered employees and qualified dependents. Additionally, claims for medical services rendered in 1972 had been filed by December 31, 1972 but had not yet been completely processed and paid.

47. The taxpayers sought advice from Aetna and Prudential regarding how to reasonably determine the amount of their liability for medical services rendered to employees and qualified dependents but unpaid by the taxpayers at any given time. Aetna and Prudential advised the taxpayers that the amount of that liability could be reasonably determined by taking a percentage of the payments made by the taxpayers for medical care benefits in a prior period, and they supplied the taxpayers with the relevant percentages. The Aetna percentages were to be applied to the payments made in the prior three-month period. The Prudential percentage figure was to be applied to the payments made in the prior twelve-month period. Periodically, Aetna and Prudential provided the taxpayers with such paid-claim information.

48. Prudential's analysis consisted of a study of the taxpayers' experience regarding the actual lag between the incurral and payment of claims and produced a single percentage to be applied to the aggregate of all paid claims without differentiating categories of benefits. By studying the actual lag between incurral and payment of claims for a twelve-month period, Prudential believed that it could determine the percentage of a year's paid claims which rep-

resented the incurred but unpaid claims. In this study, a weighted average number of days lag per claim was derived by averaging both the number of days lag for each claim and the amount of each payment. The weighted average number of days was then divided by 365 to determine a percentage lag factor.

49. Aetna's percentages were Aetna's standard lag factors for each of the four categories of medical care benefits. These standard lag factors were derived by Aetna's actuaries' study of Aetna's experience regarding the actual lag between incurral and payment of claims for its entire book of medical care benefit plans (both insured and uninsured). By studying the actual lag between incurral and payment of claims, Aetna believed that it could determine the percentage of a given amount of paid claims which represented the incurred but unpaid claims at a given time. In this study, claims were grouped by month of incurral and then analyzed to determine the amounts and percentages of those claims which were paid in the first month and each of the following months. The analysis of twelve months of incurred claims was then combined and adjusted, among other things, for inflation and for application to the amount of claims paid in a three-month period.

50. Plaintiffs' Exhibit 11 is a true and correct copy of a letter dated October 17, 1972 from Jeremiah Kelly of Prudential to Robert A. Bussey, Corporate Insurance Manager of General Dynamics Corporation, which was sent on or about that date.

51. Plaintiffs' Exhibit 12 is a true and correct copy of a letter dated October 26, 1972 from James D. Holland of Aetna which was sent on or about that date to R. A. Bussey, Corporate Insurance Manager of General Dynamics.

52. For the calendar year 1972, the taxpayers established accrual/reserve accounts to reflect the liability which they thought they had under the plans for medical services

rendered to employees and their qualified dependents. The accounting departments at each division and subsidiary established a balance in the account at year-end (December 31, 1972) to reflect the liability which that division or subsidiary believed that it had for medical services rendered to employees and their qualified dependents during 1972 but unpaid at December 31, 1972. The amounts referred to in the prior sentence were determined as follows:

A. Corporate Office: The balance at December 31, 1972 of $25,828.19 for Prudential was calculated by taking the total drafts issued for Corporate Office medical claims (insured and service contract) for the period January through December, 1972—$95,695.41—and multiplying that total by 26.99%. The balance at December 31, 1972 of $640 for Aetna was the amount of reserves attributable to the Corporate Office for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance.

B. Fort Worth: The balance at December 31, 1972 of $1,388,728 was calculated by taking the amount of reserves attributable to Fort Worth for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$1,115,862—and then adding an accrual for December, 1972 as a provision for additional expenses for medical care benefits (derived by multiplying an expense accrual rate for health care per individual for Fort Worth by the number of persons covered)—$497,308.99—and then subtracting the drafts for medical benefits which had cleared in December, 1972—$224,443.13.

C. Convair—San Diego: The balance at December 31, 1972 of $1,756,619 for Aetna was calculated by taking the amount of reserves attributable to Convair—San Diego for the medical care plan which were returned by Aetna when the taxpayers switched to self-insurance—$1,462,134—and then adding an accrual for October

through December, 1972 as a provision for additional expenses for medical care benefits (derived by multiplying an expense accrual rate for health care per individual for Convair by the number of persons covered)—$1,307,117—and then subtracting the drafts for medical benefits which had cleared in the October through December, 1972 period—$955,618—and subtracting fees for that period for administration of the service contract by Aetna—$50,551—and then subtracting a figure to discount the reserve by a 6% factor for a present value allowance—$6,463. The balance at December 31, 1972 of $493 for Prudential was calculated by taking the reserves attributable to Convair—San Diego which were returned by Prudential—$319—and adding a provision for additional expenses.

D. Electric Boat: The balance at December 31, 1972 of $1,235,467.47 was calculated as follows. An amount—$1,055,879—as a reserve for incurred but unpaid claims was determined by multiplying the total payments for Electric Boat medical claims (insured and service contract) for the period December, 1971 through November, 1972—$3,912,114—by 26.99%. A provision for additional medical care expenses for December, 1972—$336,164—was added; this amount was derived by multiplying an expense accrual rate for health care per individual for Electric Boat by the number of persons covered ($74,526 of this amount was from employee contributions by payroll deductions). Then the charges to the account for drafts issued in December, 1972 were subtracted—$156,576.53.

E. Quincy: The balance at December 31, 1972 of $715,000 was calculated by taking the total drafts issued for Quincy medical claims (insured and service contract) for the period January through December, 1972—$2,647,970—and multiplying that total by 26.99% and rounding up to the next $1,000.

F. Electro Dynamic/Avenel: The balance at December

31, 1972 of $21,574 was calculated by taking the total of medical care benefit payments for Electro Dynamic/Avenel for the period December, 1971 through November, 1972 and multiplying that total by 26.99%.

G. Pomona: The balance at December 31, 1972 of $595,727.57 for Aetna was calculated by taking the amount of reserves attributable to Pomona for the medical care plan which were returned by Aetna when the taxpayers switched to self-insurance—$375,150—and then adding an accrual for the period October through December, 1972 as a provision for additional expenses for medical care benefits—$593,508.90—and then subtracting the drafts for medical benefits which had cleared in the period October through December, 1972—$372,931.33. The balance at December 31, 1972 for Prudential of $32 was the amount of reserves attributable to Pomona returned by Prudential.

H. Electronics: The balance at December 31, 1972 of $334,617 for Aetna was calculated by taking the amount of the reserves attributable to Electronics for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$256,064—and then adding an accrual for the period October through December, 1972 as a provision for additional expenses for medical care benefits—$257,600—and then subtracting the drafts for medical benefits which had cleared in the period October through December, 1972—$179,048. The balance at December 31, 1972 of $578 for Prudential was calculated by taking the reserves returned by Prudential—$502—and then adding a provision for monthly expenses for medical benefits for the period October through December, 1972—$315—and then subtracting drafts which had been paid in the period—$238.

I. Freeman Coal: The balance at December 31, 1972 of $30,199.43 was calculated by taking the total payments for medical benefits for Freemen Coal for the year 1972—

$111,891.20—and multiplying that total by 26.99%.

J. Marblehead Lime: The balance at December 31, 1972 of $37,839 was calculated by taking the medical benefit payments for Marblehead Lime for the period July, 1971 through June, 1972—$140,196—and multiplying that total by 26.99%.

K. Material Service: The balance at December 31, 1972 of $85,321 was calculated by taking the medical benefit payments for Material Service for the period January through December, 1972—$316,121—and multiplying that total by 26.99%.

L. United Electric Coal: The balance at December 31, 1972 of $10,371.45 was calculated by taking the medical benefit payments for United Electric Coal for the year 1972—$38,427.01—and multiplying that total by 26.99%.

M. Stromberg-Carlson: The balance at December 31, 1972 of $80,036 for Aetna was calculated by taking the amount of reserves attributable to Stromberg-Carlson for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$71,321—and then adding a provision for additional expenses for medical care benefits for the period October through December, 1972—$59,138—and then subtracting the drafts for medical benefits which had cleared in the period October through December, 1972—$50,423. The balance at December 31, 1972 of $96,551 for Prudential was calculated by taking the amount of reserves for medical care benefits attributable to Stromberg-Carlson which were returned by Prudential—$141,258—and then adding a provision for additional monthly expenses for medical care benefits for the period October through December, 1972—$54,075—and then subtracting the drafts which were issued for medical benefits in the period October through December, 1972—$60,964—and subtracting $37,818 which was reclassified into another liability account.

N. DatagraphiX: The balance at December 31, 1972 of $65,478 was calculated by taking the amount of reserves attributable to DatagraphiX for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$64,954—and then adding an accrual for the period October through December, 1972 as a provision for additional expenses for medical care benefits—$56,040—and then subtracting the drafts for medical benefits which had cleared in the October through December, 1972 period—$52,727—and subtracting the Aetna administrative service fee for that period—$2,789.

The monthly provision for additional expenses for medical care benefits referred to in the preceding subparagraphs was derived by multiplying an expense accrual rate for health care benefits per individual (which rate was provided by the applicable insurance company) by the number of persons covered by the benefits at the facility. The references to balances for Prudential and Aetna in the preceding subparagraphs are to the self-insured plans administered by each company.

53. Plaintiffs' Exhibits 13 through 26 are schedules prepared and submitted by the divisions and subsidiaries of General Dynamics Corporation in 1973 to the General Dynamics Corporation corporate office, which schedules analyze the accrual/reserve account for self-insured medical benefit plans for each unit for the year 1972 and set forth the balance in the account at December 31, 1972.

54. Plaintiffs' Exhibit 27 is a schedule prepared in 1973 analyzing the medical care benefit self-insurance accrual/reserve account of General Dynamics Corporation as a whole and its divisions for the year 1972 with the December 31, 1972 balances in the account.

55. The balance in the accrual/reserve accounts for medical care benefits at December 31, 1972, without adjustments was $6,481,099.

56. There were drafts for medical care benefits which

were issued and outstanding but which had not cleared the system and been paid by the taxpayers' funds at December 31, 1972 in the amount of $501,277. These had not been charged to the accrual/reserve account by December 31, 1972. The balance in the accrual/reserve accounts as of December 31, 1972 (after adjusting for the outstanding drafts) was $5,979,822.

57. Plaintiffs' Exhibit 28 is a true and correct copy of a letter dated June 28, 1973 from James D. Holland, which he sent to General Dynamics Corporation on or about that date, setting forth the amount of issued drafts for the taxpayers' medical care benefits as of December 31, 1972 as reflected on Aetna's books but which had not yet been paid.

58. The balance of $5,979,882 in the medical care benefits accrual/reserve account was taken as an adjustment on Schedule M of the taxpayers' consolidated federal income tax return for 1972. This amount was carried as a liability on the books of the taxpayers at December 31, 1972, but was not deducted on the taxpayers' consolidated 1972 federal income tax return.

59. The balance of $5,979,822 in the taxpayers' accrual/reserve account as of December 31, 1972 included a provision for certain extended liability features under the medical care benefit plans administered by Aetna. The extended liability feature was a provision under the major medical plans which provided that, if a family member was totally disabled by reason of a non-occupational injury or disease on the date his coverage terminated, either because of termination of employment or termination of the plan, major medical benefits would be extended during the continuance of the disability for up to twelve months. The portion of the taxpayers' accrual/reserve accounts which was for this extended liability feature is not in issue in this case. The reserve amount for such extended liability features at December 31, 1972 was $404,533. The balance

in the accrual/reserve accounts as of December 31, 1972 (after adjusting for the extended liability feature reserve) was $5,575,289.

60. The first two pages of Plaintiffs' Exhibit 29 are a true and correct copy of a letter from Dennis D. Sheehan of Aetna, dated July 26, 1974, which was sent on or about that date to J. A. Hawkins, Director of Employee Services of General Dynamics Corporation, and which sets forth the amount of the reserve for the extended liability feature of the medical care benefit plans administered by Aetna as of December 31, 1972. Page three of Plaintifs' Exhibit 29 is a true and correct copy of a schedule showing the amounts paid in 1973 on the taxpayers' medical care benefit claims which were incurred in 1972 or earlier for the plans administered by Aetna.

61. Aetna prepared a computer printout listing all of the taxpayers' medical care benefit claims paid in 1973 (with the amounts which were paid) on claims incurred in 1972 or earlier for plans administered by Aetna. Plaintiffs' Exhibit 30 is a true and correct copy of pages from that computer printout, with names deleted.

62. Aetna prepared a computer printout listing all of the taxpayers' medical care benefit claims paid in 1974 (with the amounts which were paid) on claims incurred in 1973 or earlier for plans administered by Aetna. Plaintiffs' Exhibit 31 is a true and correct copy of pages from that computer printout, with names deleted. The 1974 computer printout shows that $35,282.69 was paid in 1974 on claims incurred in 1972 or earlier years and that an additional $983.82 was paid in 1973 on such claims.

63. Plaintiffs' Exhibit 32 consists of true and correct copies of schedules prepared by Prudential listing amounts which were paid in 1973 and the first six months of 1974 on the taxpayers' medical care benefit claims administered by Prudential in groups by claim incurral dates. Plaintiffs' Exhibit 33 is a true and correct copy of a schedule pre-

pared by Prudential listing 1972 incurred medical care benefits claims listed on the computer in 1973 but probably paid in 1972.

64. Plaintiffs' Exhibit 34 consists of true and correct copies of pages from the computer printout prepared by Prudential listing medical care benefit claims of the taxpayers paid in 1973, with names deleted. Plaintiffs' Exhibit 35 consists of true and correct copies of pages from the computer printout prepared by Prudential listing 1972 medical care benefit claims listed on the computer in 1973, with names deleted, which claims were probably paid in 1972.

65. Plaintiffs' Exhibit 36 consists of true and correct copies of pages from a computer printout prepared by Prudential listing medical care benefit claims of the taxpayers paid in the first six months of 1974, with names deleted. Plaintiffs' Exhibit 37 consists of true and correct copies of pages from a computer printout prepared by Prudential listing medical care benefit claims of the taxpayers paid in the period July 1, 1974 through July 14, 1975, with names deleted. Prudential's records show that $18,597.91 was paid in the last six months of 1974 and an additional $700.09 was paid in June, 1974 on the taxpayers' medical care benefit claims which were incurred in 1972.

66. The Aetna and Prudential computer printouts show that $5,004,891 was paid out in 1973 on the taxpayers' medical care benefit claims which were incurred in 1972 or earlier and that $80,279 was paid out in 1974 on such claims.

67. A comparison of the year-end balance in the accrual/reserve accounts (adjusted to delete the extended liability portion of the reserve and the drafts which were outstanding)—$5,575,289—and the amounts paid in 1973 and 1974 (adjusted for the drafts outstanding)—$4,583,893—shows that 82.2% of the taxpayers' 1972 year-end accrual/reserve was subsequently paid.

68. On or about September 15, 1973, the taxpayers timely filed their consolidated federal income tax return for 1972. The taxpayers did not deduct the $5,575,289 on that return. All taxes due for 1972 have been paid.

69. On or about February 22, 1977, the plaintiffs filed a timely claim for refund for 1972 with the Internal Revenue Service, which was amended on or about September 21, 1978, claiming, *inter alia,* a deduction for the $5,575,289 and a refund of $31,708 plus interest. Plaintiffs' Exhibit 38 is a true and correct copy of said claim for refund, and Plaintiffs' Exhibit 39 is a true and correct copy of said amendment.

70. On or about January 26, 1979, the plaintiffs executed Form 3363 (Acceptance of Proposed Disallowance of Claim for Refund or Credit) and Form 2297 (Waiver of Statutory Notification of Claim Disallowance) in respect to their claim for refund for 1972.

71. If the taxpayers had calculated their 1972 year-end accrual/reserve balances strictly in accordance with the percentage figures supplied by the insurance companies, the balance in the taxpayers' accrual/reserve accounts for medical care benefits at December 31, 1972 without adjustments would have been $5,888,301 ($3,797,693 for the Aetna plans and $2,090,608 for the Prudential plans) rather than $6,481,099 ($4,221,846 for the Aetna plans and $2,259,253 for the Prudential plans). [See ¶55.]

	Aetna Plans	Prudential Plans	Total
Reserve Balance at 12/31/72 without adjustments	$4,221,846	$2,259,253	$6,481,099
Recalculated Reserve Balance at 12/31/72 without adjustments	3,797,693	2,090,608	5,888,301
Difference	$ 424,153	$ 168,645	$ 592,798

After the adjustments referred to in Paragraphs 56 and 59, the balance in such recalculated accrual/reserve accounts as of December 31, 1972 would have been $4,982,491.

72. At December 31, 1973, the differences between the balances in the accrual/reserve accounts for medical care benefits and the amounts for such reserves recalculated according to the advice of Aetna and Prudential had been substantially eliminated. The balances at December 31, 1973 in such accounts and the recalculated balances are as follows:

	Aetna Plans	Prudential Plans	Total
Reserve Balance at 12/31/73	$3,806,650	$1,916,687	$5,723,337
Recalculated Reserve Balance at 12/31/73	3,777,302	1,928,676	5,705,978
Difference	$ 29,348	[$ 11,989]	$ 17,359

73. Plaintiffs Exhibit 41 sets forth the amounts of claims paid in 1972 and 1973 on the taxpayers' medical care benefit plans administered by Prudential.

74. Plaintiffs Exhibit 42 sets forth the amounts of the recorded claims in July, August and September, 1972 on the taxpayers' medical care benefit plans administered by Aetna.

75. Plaintiffs Exhibit 43 sets forth the calculation of the 1972 year-end accrual/reserve balances had they been calculated by taxpayers strictly in accordance with the percentage figures supplied by Aetna and Prudential.

76. Defendant's Exhibits 1 and 2 are true and correct copies of Prudential claims manuals, which set forth rules, guidelines and procedures provided by Prudential for processing claims attributable to medical treatments and services incurred by persons covered by group health insurance, and for ascertaining whether medical services and

treatments were within the scope of the group health plans, during periods prior to October 1, 1972. They were revised and updated from time to time. These rules, guidelines and procedures (subject to any relevant updates or revisions) are substantially similar to rules, guidelines and procedures provided by Prudential for processing claims attributable to the medical treatments and services incurred by plaintiffs' employees, and for ascertaining whether medical services and treatments were within the scope of plaintiffs' medical care plans, during the period October 1, 1972, through December 31, 1972.

77. Defendant's Exhibits 3 through 6 are true and correct copies of portions of Aetna claims manuals, which set forth rules, guidelines and procedures followed by Aetna in processing claims attributable to the medical treatments and services incurred by plaintiffs' employees, and in ascertaining whether medical services and treatments were within the scope of plaintiffs' medical care plans, during the period October 1, 1972, through December 31, 1972.

78. Defendant's Exhibits 7 through 20 are true and correct copies of Aetna claims letters and interoffice communications.

LYNNE E. MCNOWN	[SIGNATURE]
Attorney for Plaintiffs	Attorney for Defendant

PLAINTIFFS' EXHIBIT 1

AGREEMENT

This Agreement entered into by and between THE GENERAL DYNAMICS CORPORATION (hereinafter called the Policyholder) and THE PRUDENTIAL INSURANCE COMPANY OF AMERICA (hereinafter called Prudential).

WITNESSETH, THAT:

WHEREAS, Prudential heretofore issued to the Policyholder its Group Policies Nos. GO-14500 (under date of November 1, 1958), GC-14500 (under date of July 1, 1962), GS-14500 (under date of June 1, 1963), GW-14500 (under date of April 1, 1966) and GZ-14500 (under date of May 16, 1964) providing, among other coverages, Medical Expense Insurance Coverages for certain employes of the Policyholder and their dependents; and

WHEREAS, said Medical Expense Insurance Coverages as provided under said Group Policies are to be terminated with respect to certain classes of said employes and their dependents, at the expiration of September 30, 1972; and

WHEREAS, the Policyholder wishes an immediate financial settlement under said terminating Medical Expense Insurance Coverages; and

WHEREAS, final determination of such immediate financial settlement cannot be made at this time because Prudential's accrued liability for payment of claims under said terminating Medical Expense Insurance Coverages extends beyond the aforesaid date of termination;

NOW, THEREFORE, for and in consideration of the premises and the mutual agreements of the parties hereto expressed, it is mutually stipulated, covenanted and agreed as follows:

(1) The Policyholder hereby accepts the liability for all payments to be made under said terminating Medi-

cal Expense Insurance Coverages with respect to claims submitted thereunder on and after October 1, 1972 and, subject to the further provisions hereof, agrees to make such payments upon receipt of satisfactory notice and proof.

(2) Notwithstanding (1) above, on or after October 1, 1972 Prudential may handle any claim under said terminating Medical Insurance Coverages in such manner as it shall deem appropriate, whether or not, with respect to such claim, any demand has been made of the Policyholder or any payment has been made by the Policyholder. In such an event, Prudential will give notice to the Policyholder. Upon notice from Prudential to the Policyholder of its intention to handle any such claim, the Policyholder shall transmit to Prudential all information and forms pertaining to such claim. Prudential shall notify the Policyholder of the amount of any payments made by it pursuant to the provisions hereof and upon receipt of such notice the Policyholder shall reimburse Prudential for the amount so paid plus the amount of any expenses incurred by Prudential in connection with any payments so made.

(3) Prudential does hereby agree to pay to the Policyholder, or any designee indicated in writing by the Policyholder, an amount of money equal to the amount of the Unrevealed Claim Charges established by Prudential for said terminating Medical Expense Insurance Coverages as of the expiration of September 30, 1972, reduced by the amount of all the bank drafts on Prudential which are issued prior to October 1, 1972, in payment of claims under said terminating Medical Expense Insurance Coverages, and clear the Prudential accounting system after September 30, 1972. The amount of said bank drafts is part of the said Unrevealed Claim Charges.

Since the exact amount of the reduced said Charges will not be ascertained until Prudential completes the annual fiscal accounting and dividend determination for all of the Policyholder's Group Insurance Coverages under Group Policies Nos. GO-14500, GC-14500, GS-14500, GW-14500, and GZ-14500 for the policy period ending June 30, 1973, a preliminary financial settlement will be made in the amount of $1,220,000 as soon as reasonably possible after October 1, 1972. The final settlement will be made as soon after June 30, 1973, as the annual fiscal accounting and dividend determination for the policy period ending June 30, 1973 is completed.

(4) The Policyholder for itself, its successors and assigns, hereby agrees with Prudential, its successors and assigns, to assume liability either directly in the manner set forth under (1) above or indirectly in the manner set forth under (2) above, and does hereby assume full liability for expenses, actions, legal fees and costs in connection with actions and demands of anyone in connection with any claim under said terminating Medical Expense Insurance Coverages submitted either to the Policyholder or Prudential on or after October 1, 1972.

IN WITNESS WHEREOF the parties have hereunto set their hands and seals this ____ day of ____ in the year 1972.

GENERAL DYNAMICS CORPORATION

Attest:
[SIGNATURE]

by [SIGNATURE]

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Attest:
[SIGNATURE]

by [SIGNATURE]
Assistant Secretary

PLAINTIFFS' EXHIBIT 2

AGREEMENT

This Agreement entered into by and between THE GENERAL DYNAMICS CORPORATION (hereinafter called the Policyholder) and THE PRUDENTIAL INSURANCE COMPANY OF AMERICA (hereinafter called Prudential).

WITNESSETH, THAT:

WHEREAS, Prudential heretofore issued to the Policyholder its Group Policies Nos. GO-14500 (under date of November 1, 1958), GC-14500 (under date of July 1, 1962) providing, among other coverages, Medical Expense Insurance Coverages for certain employes of the Policyholder and their dependents; and

WHEREAS, said Medical Expense Insurance Coverages as provided under said Group Policies are to be terminated with respect to certain classes of said employes and their dependents, at the expiration of November 30, 1972; and

WHEREAS, the Policyholder wishes an immediate financial settlement under said terminating Medical Expense Insurance Coverages; and

WHEREAS, final determination of such immediate financial settlement cannot be made at this time because Prudential's accrued liability for payment of claims under said terminating Medical Expense Insurance Coverages extends beyond the aforesaid date of termination;

NOW, THEREFORE, for and in consideration of the premises and the mutual agreements of the parties hereto expressed, it is mutually stipulated, covenanted and agreed as follows:

(1) The Policyholder hereby accepts the liability for all payments to be made under said terminating Medi-

cal Expense Insurance Coverages with respect to claims submitted thereunder on and after December 1, 1972 and, subject to the further provisions hereof, agrees to make such payments upon receipt of satisfactory notice and proof.

(2) Notwithstanding (1) above, on or after December 1, 1972 Prudential may handle any claim under said terminating Medical Insurance Coverages in such manner as it shall deem appropriate, whether or not, with respect to such claim, any demand has been made of the Policyholder or any payment has been made by the Policyholder. In such an event, Prudential will give notice to the Policyholder. Upon notice from Prudential to the Policyholder of its intention to handle any such claim, the Policyholder shall transmit to Prudential all information and forms pertaining to such claim. Prudential shall notify the Policyholder of the amount of any payments made by it pursuant to the provisions hereof and upon receipt of such notice the Policyholder shall reimburse Prudential for the amount so paid plus the amount of any expenses incurred by Prudential in connection with any payments so made.

(3) Prudential does hereby agree to pay to the Policyholder, or any designee indicated in writing by the Policyholder, an amount of money equal to the amount of the Unrevealed Claim Charges established by Prudential for said terminating Medical Expense Insurance Coverages as of the expiration of November 30, 1972, reduced by the amount of all the bank drafts on Prudential which are issued prior to December 1, 1972, in payment of claims under said terminating Medical Expense Insurance Coverages, and clear the Prudential accounting system after November 30, 1972. The amount of said bank drafts is part of the said Unrevealed

Claim Charges. Since the exact amount of the reduced said Charges will not be ascertained until Prudential completes the annual fiscal accounting and dividend determination for all of the Policyholder's Group Insurance Coverages under Group Policies Nos. GO-14500 and GC-14500 for the policy period ending June 30, 1973, a preliminary financial settlement will be made in the amount of $1,180,000 as soon as reasonably possible after December 1, 1972. The final settlement will be made as soon after June 30, 1973, as the annual fiscal accounting and dividend determination for the policy period ending June 30, 1973 is completed.

(4) The Policyholder for itself, its successors and assigns, hereby agrees with Prudential, its successors and assigns, to assume liability either directly in the manner set forth under (1) above or indirectly in the manner set forth under (2) above, and does hereby assume full liability for expenses, actions, legal fees and costs in connection with actions and demands of anyone in connection with any claim under said terminating Medical Expense Insurance Coverages submitted either to the Policyholder or Prudential on or after December 1, 1972.

IN WITNESS WHEREOF the parties have hereunto set their hands and seals this first day of December in the year 1972.

Attest:

[SIGNATURE]

Assistant Secretary

GENERAL DYNAMICS CORPORATION

by [SIGNATURE]

Executive Vice President-Finance

Attest:

[SIGNATURE]

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

by [SIGNATURE]

Assistant Secretary

PLAINTIFFS' EXHIBIT 3

AETNA LIFE & CASUALTY
151 Farmington Avenue
Hartford, Connecticut 06115

James D. Holland
Secretary
Group Division

September 20, 1972

General Dynamics Corporation
Pierre Laclede Center
St. Louis, Missouri 63105

Gentlemen:

RESERVE REFUND AGREEMENT

In connection with the adoption of the Administrative Services Contract effective October 1, 1972 the agreement described below is being entered into by Aetna Life Insurance Company and General Dynamics Corporation. This agreement applies only to the reserves held for that portion of your plan of medical and dental benefits which will no longer be insured by Aetna after September 30, 1972, and will be subject to an Administrative Services Contract thereafter. The purpose of this agreement is to allow certain reserves to be refunded to General Dynamics Corporation and to allow Aetna to use service contract drafts for all benefit payment drafts issued on and after the effective date of the Administrative Services Contract in connection with the benefits concerned, thereby facilitating the transition from an insured plan to an uninsured plan of the portion of your group insurance program to which this agreement applies.

Under this agreement, Aetna Life Insurance Company agrees that it will refund to General Dynamics Corporation reserves under the coverages affected by the Administrative Services Contract, which reserves it would other-

wise hold as of October 1, 1972 for the purpose of subsequently discharging the then outstanding liability under these coverages.

The amount of the reserves to be refunded to General Dynamics Corporation will be determined on the basis of the claim reserves shown on our experience accounting statements for such benefits as of October 1, 1972 minus the sum of (i) all drafts which have already been issued but which have not yet cleared our bank for payment as of such date, and (ii) the amount of any experience deficit indicated on such accounting statements for the experience rating group involved. The payout of reserves so determined to be available for refund will be accomplished in such monthly amounts as mutually agreed upon. It is expected that the reserve refund will occur within the first four months following October 1, 1972.

Aetna will continue to be liable for and pay the drafts indicated in item (i) of the preceding paragraph which are presented to its bank for payment during the period October 1, 1972–September 30, 1973.

In return for the refund of the reserves described above, General Dynamics Corporation agrees to allow all drafts issued by Aetna on and after October 1, 1972 with respect to claims payable under the coverages affected by the Administrative Services Contract to be charged against the funds of General Dynamics Corporation. General Dynamics Corporation also agrees to make sufficient funds available for this purpose irrespective of the in-force status of the service contract at that time. This will then allow Aetna to use service contract drafts, which would in time be charged against your funds, for all claim drafts issued on and after October 1, 1972.

As soon as practicable after October 1, 1973 a final accounting will be prepared with respect to the amounts described in the second prior and third prior paragraphs of this agreement which are known at that time. Based on

this accounting, a settlement will be made for any adjustment necessary to make up the difference between the estimated figures on which the reserve refund payments may have been made and the corresponding applicable actual figures. If this accounting indicates that the amount of the settlement is due your Company, such amount will accompany the accounting. If the amount of the settlement is due Aetna, such amount will be payable by your Company to Aetna within 30 days following the date the accounting is mailed to your company.

Since the monthly reserve refund payments by Aetna and the settlement referred to in the previous paragraphs will result in the complete refund of all available reserve funds for the coverages affected, General Dynamics Corporation agrees to reimburse Aetna for the amount of any drafts issued prior to October 1, 1972 which clear our bank for payment on and after the accounting date used in the previous paragraph, irrespective of the in-force status of the Administrative Services Contract at that time. Such reimbursement will be due within 30 days following the presentation by Aetna to your Company of an accounting for such amount. We expect to submit any such accountings at subsequent renewals of the service contract arrangement and periodically thereafter if the service contract has been terminated.

Very truly yours,

/s/ JAMES D. HOLLAND

James D. Holland
Secretary

Accepted by GENERAL
DYNAMICS CORPORATION

[SIGNATURE]

Vice President,
Industrial Relations

26 September 1972

PLAINTIFFS' EXHIBIT 9

PART II
YOUR BASIC MEDICAL EXPENSE BENEFITS AND MAJOR MEDICAL EXPENSE BENEFITS

* * * * *

HOSPITAL EXPENSE BENEFITS

This coverage provides benefits for room and board and other services in connection with a hospital confinement for which a room and board charge is made and which is ordered by a physician as the result of a non-occupational injury or sickness, other than pregnancy. If the initial hospital visit is for emergency care within 72 hours after an accident or the onset of serious and sudden illness, or is for surgery, the requirement that a room and board charge be made shall not apply in connection with any charge included as part of the "Other Services" section.

Room and Board Benefits—The benefit payable is equal to the charges made by a hospital for room and board and all regular daily services and supplies. The daily benefit will not exceed the Maximum Daily Room and Board Benefit shown in the Plan Summary.* The maximum benefit per confinement will not exceed the Total Room and Board Benefit also shown in the Plan Summary.

Other Services—This benefit pays the cost of hospital services and supplies, such as, operating room, X-rays, medicines, etc. administration of anaesthetics by a physician and use of ambulance service for travel to and from the hospital. The services and supplies must be in connection with the hospital confinement. The benefit will not exceed the Maximum Other Services Benefit shown in the Plan Summary.

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* Wherever "Plan Summary" appears in this Part II, refer to Plan Summary (Part II).

Full benefits will be available for each confinement due to a different cause. If more than one confinement is needed for the same cause, full benefits will be available for each, provided the confinements are separated by complete recovery, or, in the case of your own confinement, your return to active work.

SURGICAL EXPENSE BENEFITS

This coverage provides benefits for the fee of a physician for performing an operation needed because of a non-occupational injury or sickness, other than pregnancy. The operation may be performed in the physician's office, in a hospital or anywhere else.

This plan will pay the fee the physician charges, up to the amount listed for the operation in the Schedule of Surgical Procedures included in the Plan Summary. The Maximum Surgical Expense Benefit for all operations due to the same causes and not separated by complete recovery, or, in the case of operations on you, not separated by your return to active work, is shown in the Plan Summary.

MATERNITY EXPENSE BENEFITS

Hospital Expenses

The plan will pay benefits, up to the Maternity Hospital Expense Maximums shown in the Plan Summary, for the following expenses incurred in connection with a hospital confinement due to pregnancy of a female Employe or of an Employe's wife. The confinement must be ordered by a physician and begin while she is covered or during the nine months following the date the coverage ended.

(1) The hospital's charge for room and board and all other services for medical care and treatment, excluding professional services;

(2) Physician's fees for administering anaesthetics in the hospital;

(3) Charges for ambulance service for travel to and from the hospital.

Obstetrical Expenses

The plan will also pay the fee of a physician for an obstetrical procedure, up to the Maternity Surgical Expense Maximum shown in the Plan Summary. The procedure must be performed while Maternity Hospital Benefits apply.

HOSPITAL MEDICAL EXPENSE BENEFITS

This coverage provides benefits for visits by a physician during a confinement in a hospital resulting in a room and board charge. The confinement may be due to any non-occupational injury or sickness other than pregnancy.

For Confinement During Which No Operation is Performed—The plan will pay the physician's fee, up to the Hospital Medical Daily Limit shown in the Plan Summary.

For Confinement During Which an Operation is Performed—The plan will pay the physician's fee for visits made before the date of the operation, up to the Hospital Medical Daily Limit shown in the Plan Summary.

The Maximum Hospital Medical Benefit for each confinement is shown in the Plan Summary.

Full benefits will be available for each confinement due to a different cause. If more than one confinement is needed for the same cause, full benefits will be available for each, provided the confinements are separated by complete recovery, or, in the case of your own confinement, by your return to active work.

DIAGNOSTIC X-RAY AND LABORATORY EXPENSE BENEFITS

(Effective July 1, 1973)

This coverage provides benefits for diagnostic X-ray and laboratory examinations ordered by a physician and

made necessary by a non-occupational injury or sickness, other than pregnancy.

The plan will pay the fee charged, at the Rate of Payment shown in the Plan Summary. The total payment will not exceed the Maximum Diagnostic X-Ray and Laboratory Expense Benefit shown in the Plan Summary.

These benefits do not apply to:

(1) expenses paid or payable under other parts of the plan other than Major Medical Expense Benefits:
(2) expenses in connection with dental work or treatment;
(3) routine "check-up" examinations;
(4) examinations made during a hospital confinement for emergency care after an accident, for surgery, or for which room and board charges are made.

EMERGENCY CARE EXPENSE BENEFITS

This coverage provides benefits for a doctor's charges incurred for the initial visit for emergency care within 72 hours of an accident or the onset of serious and sudden illness. Only non-occupational accidents and illnesses are covered. The visit may take place in a hospital's outpatient department or in a doctor's office.

These benefits do not apply to:

(1) Services if charged for in a hospital's charges for emergency care;
(2) An expense if any benefit is payable with respect to that expense under other parts of the plan other than Major Medical Expense Benefits.

RADIOTHERAPY EXPENSE BENEFITS

Benefits are provided for radiotherapy treatments, including professional services and materials and facilities used, toward the expenses incurred which are not paid under other parts of the Plan. For benefits to be payable,

the therapy must be ordered by a physician and required for sickness or accidental bodily injury, other than for diagnostic purposes.

The Plan will pay the amount charged up to the amount listed for the procedure in the Schedule of Radiotherapy shown in the Plan Summary.

The total payment will not exceed the Maximum Radiotherapy Benefit shown in the Plan Summary.

When two or more treatments are administered on the same day, the amount payable for all such treatments will not exceed the amount for the treatment with the highest limit.

MAJOR MEDICAL EXPENSE BENEFITS

This coverage provides benefits for the eligible expenses described below when incurred for the care and treatment of a non-occupational sickness or injury. Payment of benefits for you or a covered dependent will begin when the deductible shown in the Plan Summary has been satisfied.* Benefits will be paid at the rate shown in the Plan Summary for all eligible expenses the individual incurs during the rest of the year (except as provided below in connection with mental illness or functional nervous disorder).

* But the deductible does not apply to eligible expenses for the following services (under the conditions explained below):

(1) Hospital room and board;
(2) Other hospital services;
(3) Ambulance service;
(4) Anaesthetics and their administration.

Conditions in which the deductible does not apply—(a) Hospital confinement for which room and board charges are made, or (b) in connection with in-hospital surgery, or (c) the initial hospital visit for emergency treatment within 72 hours of an accident or the onset of sudden and serious illness.

When the deductible does not apply, benefits will be paid at the rate shown in the Plan Summary; the remainder of such expenses may not be applied to the deductible.

ELIGIBLE EXPENSES

The eligible expenses are the following services and supplies:

Hospital Room and Board—Charges for room and board. (For private accommodations, the eligible expenses are subject to the limit in the Plan Summary. Intensive care units are not considered private accommodations.)

Other Hospital Services—Charges for services such as operating room, drugs, X-rays, laboratory tests, administration of anaesthetics, etc.

Ambulance Service for travel to and from the hospital.

Expenses In or Out of the Hospital

Doctors services—Surgery, home, office and hospital visits, and other medical care and treatment.

Nursing care—Private duty nursing by a registered graduate nurse.

Speech therapy—By a qualified speech therapist to restore speech loss, or correct an impairment, due to (a) a congenital defect for which corrective surgery has been performed, or (b) an accident or sickness except a functional nervous disorder.

Physiotherapy—Treatment by a physiotherapist.

Dental treatment due to accident—As an additional feature, the following dental services received within 12 months of an accident are eligible: Treatment by a physician, dentist, or dental surgeon of injuries to natural teeth including replacement of such teeth, treatment of a fractured jaw, and related X-rays.

Expenses Outside the Hospital

Anaesthetics and their administration.

X-ray and laboratory examinations.

X-ray and radium treatments and treatments with other radioactive substances.

Medical supplies—Drugs and medicines dispensed by a licensed pharmacist; blood and blood plasma; artificial limbs, eyes and larynx; electronic heart pacemaker; surgical dressings; casts; splints; trusses; braces; crutches; rental of wheel chair, hospital bed, or iron lung; oxygen and rental of equipment for its administration.

DEDUCTIBLE CARRY-OVER PROVISION

A new deductible will apply each calendar year. However, expenses incurred in the last three months of a year which are applied against that year's deductible can also be applied toward the deductible for the next year and thus reduce or eliminate that year's deductible.

MENTAL ILLNESS OR FUNCTIONAL NERVOUS DISORDER

Major Medical Expense benefits for all eligible expenses incurred during a hospital stay resulting in a room and board charge or for charges in connection with administration of convulsive therapy will be determined in the regular way. Otherwise, the following will apply:

After satisfaction of the usual deductible, benefits for eligible expenses will be payable at the rate shown in the Plan Summary with respect to such expenses. For professional psychiatric services, not more than the number of visits shown in the Plan Summary, nor more than the dollar limit per visit shown there will be counted.

THE FOLLOWING EXPENSES ARE NOT ELIGIBLE

(1) Expenses for eye refractions; fitting of glasses or hearing aids; expenses for cosmetic surgery unless required as a result of an accident sustained while covered.

2. Expenses for nursing care or physiotherapy or speech therapy rendered by you or your spouse, or a child, brother, sister, or parent of yourself or spouse.
3. Expenses for services, treatments or supplies to the extent that benefits are provided for such expenses under any other coverage of this Plan.
4. Expenses for pregnancy, except that if a pregnancy commences while a female employe or employe's wife is covered the following expenses will be covered:
   (a) Expenses, while hospitalized, solely for pernicious vomiting or toxemia with convulsions;
   (b) The following surgery and related hospital and other expenses after surgery: Caesarean after 6 months; intra-abdominal surgery after pregnancy terminates; operation for extra-uterine pregnancy.
5. Expenses resulting from an act of war, declared or undeclared (including resistance to armed aggression) occurring while covered.

Pre-existing Conditions

If you or your family members have undergone treatment for any condition within 90 days before the effective date of your insurance, you will be eligible for benefits for that condition at the end of a 90 day period which ends while you or your dependent is covered, and during which no medical expenses or treatment is incurred for that condition.

In any event, an employee will become eligible for benefits for pre-existing conditions after completing a 6 month period of continuous employment on a full-time basis while covered for major medical benefits.

* * * * *

Also see "General Exclusions – Medical Expenses" on a later page.

MAXIMUM PAYMENT

The Plan will pay up to the Maximum Benefit shown in the Plan Summary for you and for each of your covered dependents for all causes combined for a lifetime.

Automatic Restoration—On the first of each year, each covered person who then has benefits charged to his overall maximum will automatically have an amount restored for future use. The amount to be restored each year will be $1,000, or the amount needed to bring the maximum back to the full amount, whichever is less.

Request for Restoration—If a person who has received at least $1,000 in major medical benefits recovers and furnishes satisfactory evidence of good health, his overall maximum will be restored in full.

GENERAL EXCLUSIONS—MEDICAL BENEFITS

The medical expense coverages do not cover:

Charges for a service or supply (a) furnished by or for any government, unless the government is other than the U.S. Government and payment is legally required, or (b) to the extent any benefit is provided by any law or governmental program under which a person is or could be covered.

Anything not ordered by a physician or not reasonably necessary for medical care of sickness or injury; check-up examinations and tests not reasonably necessary to medical treatment.

Any charge for a service or supply to the extent to which it exceeds the smaller of (a) the usual charge by the provider when there is no insurance and (b) the general level of charges for a comparable service or supply made by other providers within the same county (or larger area if necessary to get a representative cross-section).

Charges for physicians' services or X-ray examinations for mouth conditions due to periodontal or periapical disease or any condition involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue, except for treatment or removal of malignant tumors. (This exclusion does not apply to certain dental treatment as described under Major Medical Expense Benefits.)

Physicians' services for (a) weak, strained, flat, unstable or imbalanced feet, or metatarsalgia or bunions, except open cutting operations, or (b) corns, calluses or toenails, except removing nail roots and care prescribed by an M.D. or D.O. treating a metabolic or peripheral-vascular disease.

Charges for eye refractions or other examinations to determine the need for, or the adjustment of, eye glasses.

Expenses for services or supplies to the extent the person receives payment or reimbursement for such expenses as a result of legal action or settlement.

MISCELLANEOUS MEDICAL EXPENSE PROVISIONS

Coordination With Other Plans

The purpose of our health plan is to help meet the covered expenses you and your dependents actually incur. Sometimes, though, because individuals have medical care protection under more than one plan, the total benefits may exceed the actual expenses. Such excess coverage tends to increase unnecessarily the cost of the plan. Therefore, your plan contains a provision coordinating it with any coverage the patient may have under other plans. The provision is designed to guard against excess coverage and help preserve the future benefits for everyone.

When a request for Benefit is made, the coordination provision governs whether our plan will pay its regular amount or whether this will be adjusted so that the bene-

fits available from all plans will not exceed 100% of the allowable expenses. An "allowable expense" is any necessary, reasonable and customary expense included in any of the plans.

If, because of the coordination provision, our plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase the patient's later benefit payments under our plan in the same calendar year, to the extent there are allowable expenses that would otherwise not be fully paid by our plan and the other plans. Thus the later benefit may be larger under our plan than would normally be allowed.

"Other plans" refer to these types of medical or dental care benefits: (a) coverage under a governmental program or required or provided by statute, and (b) group insurance or other coverage for a group of individuals, including prepayment coverage, group or individual practice coverage; (c) coverage for students sponsored by or provided through an educational institution. "Other plans" do not include benefits payable under individual policies of Accident and Health Insurance which you may have purchased on your own.

PAYMENT OF BENEFITS

It will be necessary for you to submit satisfactory written proof of each charge for which benefits are being requested, and each charge used to satisfy the deductible. You may also be required to furnish written proof that such charges were for services, treatments and supplies ordered by a physician. Therefore, be sure to keep an accurate record of each covered individual's medical expenses, and retain all bills and receipts.

EXTENSION OF MEDICAL EXPENSE BENEFITS

If the Hospital Expense, Surgical Expense, Hospital Medical Expense, Diagnostic X-Ray and Laboratory Ex-

pense Benefits and Radiotherapy Expense coverages terminate, the benefits under these coverages will be extended for three months to cover a confinement, visits by a physician during confinement, treatments, examinations or an operation resulting from a continuous total disability that began while the coverages were in force and which would have been covered had the coverages continued.

If a covered individual is totally disabled and under the care of a physician for reasons other than pregnancy when the Major Medical Expense coverage terminates, coverage will be extended during such total disability but not beyond the end of the calendar year following that in which the coverage terminates. This extension of benefits will apply only to expenses due to the sickness or injury which caused the total disability of the person.

For a pregnancy of a female Employe or Employe's wife which exists when employment terminates and which would hvae been eligible for maternity benefits had employment not been terminated, coverage will be extended for the duration of the pregnancy. If the individual is confined in a hospital at the termination of the pregnancy, the coverage will be further extended while she remains continuously confined due to the pregnancy.

TERMINATION OF PART II COVERAGE

When your employment terminates or you cease to be a member of a class eligible for coverage under this Plan your coverage under this Plan will cease. If you are required to make contributions for this coverage and if you fail to make the contributions, coverage will cease, unless terminated sooner for other reasons, at the end of the period for which contribution has been made. Satisfactory evidence of good health must be furnished before coverage can again be obtained.

Your coverage under the Plan will terminate upon discontinuance of the Plan.

Ceasing active work will be considered to be immediate termination of employment, except that if you are absent from active work because of sickness, injury or leave of absence, employment may be deemed to continue for the purposes of some of the medical expense coverage, subject to certain time limits. If you cease active work for any reason, you should find out immediately from your Employer what coverage, if any, can be continued in force so that you will be able to exercise any rights you may have under the Plan.

Dependents Coverage Only:

A dependent's coverage will terminate if dependents coverage under the Plan terminates, or if your own coverage terminates, or if he ceases to be an eligible dependent.

DEFINITIONS

Definition of Hospital

For the purpose of this Plan, a "hospital" is a legally operated institution which provides complete in-patient services for a fee, including surgical facilities, under supervision of a staff of physicians. The term does not include an institution, or part of one, which is used principally as a rest or nursing facility, or facility for the aged or for the care and treatment of drug addicts or alcholics.

Definition of Physician

For the purpose of this Plan, "physician" means a physician or surgeon who is licensed to practice medicine and perform surgery. The term also includes a licensed dentist, podiatrist or optometrist practicing in his own field.

Definition of Non-occupational Sickness or Injury

For the purpose of this Plan, "non-occupational sickness" means sickness not covered by any workmen's compensation law, occupational disease law or similar legisla-

tion: "non-occupational injury" means injury not arising out of, or in the course of, any employment for wage or profit.

PLAN SUMMARY

(Part II)

PLAN OF MEDICAL EXPENSE BENEFITS PROVIDED BY GENERAL DYNAMICS CORPORATION

Eligibility Provisions

Effective Date of Plan: December 1, 1972

Eligible Class of Employes: All Employes of the Employer's Electric Boat Division who are represented by the Patternmakers of New London, Connecticut, affiliated with the AFL-CIO.

Waiting Period: You will not become covered for these benefits until you have completed 30 days of continuous service with the Employer.

Becoming Covered: In order to obtain this coverage, it is necessary to fill in the enrollment form.

Should you not be working full-time on the day you would ordinarily become covered the coverage for yourself and your eligible dependents will be delayed until you return to full-time work.

Your coverage for a dependent will be delayed if on the date it would become effective the dependent is confined for medical care or treatment in an institution or at home. The delay will end and coverage for that dependent begin upon final medical release of the dependent from such confinement.

After your coverage becomes effective, it is necessary to notify your Employer of any change in the number of your dependents which will result in a change from one to the other of the following classifications:

(1) Employe without dependents;

(2) Employee with one dependent;

(3) Employe with more than one dependent.

If you wish to include a new dependent, you must make a separate request to your Employer.

Eligible Dependents: The dependents who are eligible for medical benefits are your spouse (unless legally separated) and unmarried children less than 19 years old.

Unmarried children who are 19 but less than 23 years old are also eligible provided they depend wholly upon you for support and are full-time students in an educational institution.

Children are eligible from birth except for hospital room and board charges during the first seven days.

Stepchildren, foster children and legally adopted children are included the same as your own children, provided they depend upon you for support, are living in the same household, and are reported for the coverage.

No one will be eligible as a dependent while covered as an employe or while in military service.

A child who is physically or mentally incapable of self-support upon attaining age 19 may be continued under the medical benefits while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. This privilege also will apply to a child who has remained in the plan beyond his nineteenth birthday if, while still covered by the plan, he later ceases to be a qualified dependent and is physically or mentally incapable of self-support and is not married. To continue a child under this provision, proof of incapacity must be furnished within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

If you have met the requirements for covering your dependents shown above, an eligible dependent will become covered immediately.

Benefits For You And Your Dependents–

Hospital Expense:

Maximum Daily Room and Board Benefit:

Prior to July 1, 1973: $60.00;

On and after July 1, 1973 but prior to July 1, 1974; $65.00;

On and after July 1, 1974; $70.00.

Total Room and Board Benefit: The person's Maximum Daily Room and Board Benefit for each day of confinement, up to 365 days.

Maximum Other Services Benefit: $800.00.

Surgical Expense: The plan will pay the fee of a physician for a surgical procedure, up to the amount listed for the procedure in the surgical schedule included as part of this Summary. The Maximum Surgical Expense Benefits payable for all operations performed during any one period of disability is $1,300. (This maximum will be increased to $1,400 effective July 1, 1973 and to $1,500 effective July 1, 1974.)

Hospital and Surgical Maternity:

Maternity Hospital Expense Maximums:

Prior to July 1, 1973: $60.00;

On and after July 1, 1973 but prior to July 1, 1974; $65.00;

On and after July 1, 1974; $70.00.

Total Room and Board Benefit: The person's Maximum Daily Room and Board Benefit for each day of confinement, up to 365 days.

Maximum Other Services Benefit: $800.00.

Maternity Surgical Expense Maximums:

	Prior to 7-1-73	Effective 7-1-73
Delivery of child or children	$100.00	$150.00
Caesarean section, including delivery	200.00	300.00
Abdominal operation for extra uterine pregnancy	200.00	300.00
Miscarriage including dilation and curettage	50.00	75.00

These benefits will not apply to any pregnancy commencing before a female Employe or an Employe's wife is covered under the plan.

Hospital Medical Expense (Physicians' Visits While Hospital Confined):

Hospital Medical Daily Limit: $10.00 for the first day and $6.00 for each day thereafter.

Maximum Hospital Medical Benefit: The applicable daily benefit for the first 366 days of confinement.

Emergency Care Expense Benefit: See page 13 of Booklet.

Diagnostic X-Ray and Laboratory Expense: (Effective July 1, 1973).

Rate of Payment: 80%.

Maximum Diagnostic X-Ray and Laboratory Expense Benefit: $75.00 during any period of twelve consecutive months.

Radiotherapy Expense:

The plan will pay up to the amount listed for the radiotherapy treatment listed in the schedule of radiotherapy included as part of this Plan Summary.

Maximum Radiotherapy Benefit: $300 per calendar year.

Major Medical Expense Benefits:

Deductible: $100.00 of eligible expenses incurred by a covered person during a calendar year ($100 for a family).

Private Room Limit: The hospital's standard semi-private room daily rate. If the hospital does not have semi-private rooms, the limit is 80% of the daily charge for its lowest rate private room.

Rate of Payment: 80% of eligible expense incurred after satisfaction of the deductible. However the plan will pay only 50% with respect to charges for treatment of mental illness or functional nervous disorder, other than convulsive therapy, not involving a hospital stay resulting in a room and board charge.

For professional psychiatric services

Visit Limit – 50 per calendar year.

Dollar Limit – $20.00 per visit (maximum benefit – $10.00 per visit).

Maximum Benefit: $15,000 for all illnesses of a covered person during his lifetime.

Schedule of Surgical Procedures

(1) "Surgical procedure" means only cutting, suturing, electrocauterization, removal of stone or foreign body by endoscopic means, or injection of sclerosing solution.

(2) This Schedule includes all surgical procedures described in (1), other than any expressly not covered by this Schedule, or by the terms of the coverage to which it applies. A consistent scheduled limit, not to exceed $650*, will be determined for any included procedure not listed.

(3) A combination of surgical procedures is considered one procedure if a scheduled limit is shown for the combination.

(4) Two or more surgical procedures performed through the same abdominal incision will be considered as one operation (that one of such procedures for which the largest maximum payment is provided by this Schedule).

(5) If, at one session, more than one operation is performed in the same operative field or through one incision, the maximum benefit will be the amount for the operation having the highest limit. But if the operations are in different fields and require separate incisions, the maximum benefit will be the amount for the field with the highest limit plus 50% of the amount for each other field.

* This amount will be increased to $700 (effective July 1, 1973) and to $750 (effective July 1, 1974). Revised surgical schedules reflecting changes in Scheduled Limits

resulting from these increases will be issued in the future as supplemental pages to your Plan Summary.

	Scheduled Limit
CARDIOVASCULAR SYSTEM	
Pericardiectomy	$433.50
Thromboendarterectomy of abdominal aorta	650.00
Valvulotomy or commissurotomy	
Aortic, pulmonic or tricuspid	650.00
Mitral	520.00
Varicose veins	
Injection of sclerosing solution into vein(s) of leg	6.50
Cutting operation, with or without injection	
Ligation and division and complete stripping	
long or short saphenous veins, unilateral	130.00
long or short saphenous veins, bilateral	216.50
long and short saphenous veins, unilateral	173.50
long and short saphenous veins, bilateral	260.00
Ligation and division of short saphenous vein at saphenopopliteal junction	80.00
DIGESTIVE SYSTEM	
Adenoidectomy	43.50
Anal papillectomy, one or more	21.75
Appendectomy	200.00
Appendicial abscess, transabdominal incision and drainage	200.00
Aspiration biopsy of liver	21.75

	Scheduled Limit
Cholecystectomy	260.00
With open exploration of common duct	303.50
Cholecystotomy	216.75
Colectomy	
Partial resection of large intestine in two stages including first stage colostomy or cecostomy	$433.50
Enterectomy	
Resection of small intestine with anastomosis or enterostomy	303.50
Excision of submaxillary gland, tumor, or both	173.50
Fissurectomy with or without sphincterotomy	86.75
Fistulectomy or fistulotomy, subcutaneous	50.00
Fistulectomy or fistulotomy, submuscular	173.50
Gastrectomy with or without vagotomy	
Subtotal or hemi-gastrectomy	346.75
Total gastrectomy	433.50
Gastroduodenostomy or gastrojejunostomy	260.00
Gastroscopy or esophagoscopy	
Diagnostic, with or without biopsy	70.00
Gastrotomy or gastrorrhaphy	216.75
Hemorrhoids	
Excision of external hemorrhoidal tabs	21.75
External hemorrhoidectomy, complete	86.75
External and internal, or internal hemorrhoidectomy	130.00
Hemorrhoidectomy and submuscular fistulotomy or fistulectomy	173.50
Hemorrhoidectomy and fissurectomy	130.00
Incision of external thrombotic hemorrhoid	20.00
Injection of sclerosing solution	8.75

	Scheduled Limit
Hernioplasty, herniorrhaphy, or herniotomy	
Epigastric, femoral, inguinal	161.75
Inguinal with orchiectomy or excision of hydrocele	173.50
Umbilical, under age 5 years	130.00
Umbilical, age 5 year or over	151.75
Incision and drainage of ischiorectal abscess	50.00
Laparotomy, exploratory	200.00
Marsupialization of cyst or abscess of liver	303.50
Pancreatectomy, total	606.75
Proctectomy complete, combined abdominoperineal, one or two stages	433.50
Proctosigmoidoscopy	
Initial	20.00
Subsequent	20.00
With biopsy	21.75
With removal of polyp	50.00
With removal of polyps	50.00
Tonsillectomy, with or without adenoidectomy	
Under age 18 years	$ 65.00
Age 18 years or over	86.75
EAR AND EYE	
Cataract	
Discission: needling of lens	
Initial	100.00
Subsequent	100.00
Extraction of lens, intracapsular, extracapsular, or linear	346.75
Enucleation eyeball	173.50
Excision of pterygium	108.50
Mastoidectomy, simple	216.75
Myringotomy, tympanotomy, plicotomy	20.00

	Scheduled Limit
Reattachment of retina	
Electrocoagulation, scleral resection, buckling or partial tubing	433.50
Light coagulation of retinal breaks	173.50
Removal of foreign body embedded in conjunctiva	10.00
Stapes mobilization	303.50
ENDOCRINE, HEMIC, LYMPHATIC SYSTEMS	
Biopsy or excision of lymph node	
Anterior scalene	65.00
Other	21.75
Excision of cyst or adenoma of thyroid	200.00
Thyroidectomy	
For malignancy with radical neck dissection	433.50
Total or complete	303.50
Total thyroid lobectomy	216.75
FEMALE GENITAL SYSTEM	
Amputation of cervix	100.00
Biopsy of cervix or endometrium	20.00
Dilation and curettage of uterus under general anesthesia	65.00
With conization	100.00
Excision or cautery destruction of Bartholin's gland or cyst	65.00
Hysterectomy	
Radical for cancer, including regional lymph nodes	433.50
Subtotal or supracervical	238.50
Total (corpus and cervix)	300.00
Repair of cystocele with or without urethrocele	151.75
Repair of cystocele, rectocele and perineoplasty, with or without repair of urethrocele	216.75

	Scheduled Limit
Repair of rectocele	130.00
Salpingectomy, oophorectomy or salpingo-oophorectomy, complete or partial, unilateral, or bilateral	200.00
INTEGUMENTARY SYSTEM	
Breast	
Mastotomy with exploration or drainage of abscess, deep	50.00
Partial mastectomy, or excision of cyst or tumor	
Unilateral	65.00
Bilateral	108.50
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes	303.50
Simple mastectomy, complete	200.00
Excision of benign lesion of skin, subcutaneous tissue or mucous membrane, lesion diameter:	
¼ inch or less	20.00
over ¼ but not over ½ inch	21.75

Excision of malignant lesion of skin or mucous membrane of:	Lesion diameter: ¼ inch or less	Lesion diameter: over ¼ inch not over ½ inch
Trunk, arms or legs	$50.00	$50.00
Face, scalp, ears, neck, hands, feet, genitalia	50.00	65.00
Eyelids, lips, mucous membrane	65.00	86.75

Incision and drainage of sebaceous cysts, furuncle, carbuncle or any other subcutaneous abscess	10.00

	Scheduled Limit
Suturing of wounds (all wounds combined)	
2½ inches or less	17.50
over 2½ but not over 5 inches	28.50
MALE GENITAL SYSTEM	
Circumcision	
Age less than 15 days	13.00
Age 15 days or older	43.50
Epididymectomy or excision of hydrocele or varicocele	130.00
Orchiectomy, unilateral	86.75
Orchiectomy, bilateral	140.00
Prostatectomy (one or two stages, complete procedure)	346.75
MUSCULOSKELETAL SYSTEM	
AMPUTATIONS, complete procedure	
Ankle, with skinplasty and resection of nerves	216.75
Arm through humerus or through radius and ulna	173.50
Digit, with or without split or Wolff graft, skinplasty, tenodesis, or definitive resection volar digital nerves	
Finger or thumb	65.00
Toe	43.50
Disarticulation of hip	346.75
Disarticulation of knee	200.00
Disarticulation of shoulder	325.00
Foot, midtarsal or transmetatarsal	151.75
Hand, midcarpal or transmetacarpal	173.50
Leg through tibia and fibula	216.75
Thigh through femur, including supracondylar	260.00
BONES	
Excision of bone cyst or chondroma:	
Humerus, radius, ulna, pelvis, femur, tibia, or fibula	216.75

	Scheduled Limit
Carpal or tarsal bones	108.50
Fractures, closed reduction of	
Ankle	
bimalleolar (including Pott's), simple	108.50
trimalleolar, simple	130.00
Astragalus or os calcis, simple	86.75
Carpal, one or more, simple	43.50
Clavicle, simple	65.00
Femur	
distal end, condyle(s), or both, simple	151.75
intertrochanteric, simple with fixation or traction	195.00
neck, simple, with fixation or traction	216.75
shaft, including supracondylar, simple	173.50
Fibula	
distal end, malleolus, or both	100.00
shaft, simple	100.00
with tibia, shafts, simple	130.00
Humerus	
medial or lateral condyle	100.00
shaft, simple	108.50
surgical neck, simple	130.00
Malar, simple or compound	50.00
Maxilla or mandible, simple or compound, with wiring of teeth	130.00
Metacarpal, simple or compound	
one	43.50
more than one	54.25
Metatarsal, simple	43.50
Nasal, simple or compound	21.75
Patella, simple	100.00
Pelvis, simple	100.00
Phalanx or phalanges, simple, one finger, thumb, or toe	21.75

	Scheduled Limit
Radius	
head or distal end, simple	65.00
shaft, with or without ulna, simple	86.75
Ribs, one or more, simple	28.25
Scapula or sternum, simple	52.00
Tarsal (other than astragalus or os calcis) one or more, simple	43.50
Tibia	
distal end, malleolus, simple	100.00
shaft, or proximal end, with or without condyle(s), or intercondylar spines, simple	108.50
with fibula, shafts, simple	130.00
Ulna, shaft, with or without radius, simple	86.75
Vertebral body (other than sacrum), one or more	130.00
Vertebral processes, one or more	34.75
Spinal fusion, two or more segments	411.75
JOINTS	
Arthrectomy	
Excision of intervertebral disc, with spinal fusion	520.00
Excision of semilunar cartilage, knee joint	216.75
Temporomandibular joint	325.00
Arthrotomy or capsulotomy with exploration, drainage, or removal of loose body	
Finger, thumb, or great toe	65.00
Hip	303.50
Shoulder, elbow, knee or ankle	216.75
Toe, other than great toe	43.50
Dislocations, closed reduction of	
Ankle or tarsal, simple	50.00
Clavicle, simple, with general anesthesia	43.50

	Scheduled Limit
Wrist, elbow or shoulder (humerus), simple	50.00
Finger, one or more joints, simple	20.00
Hip (femur) or knee (femoral-tibial joint), simple	86.75
Metacarpal, one bone, simple	20.00
Metatarsal, one bone, simple	30.50
Patella, simple	20.00
Temporomandibular, simple	30.00
Thumb, simple	20.00
Toe, one or more joints, simple	20.00
Vertebra, simple, using traction and general anesthesia	238.50
Suture or repair of joint capsule for recurrent shoulder dislocation	303.50
TENDONS, TENDON SHEATHS AND FASCIA	
Excision	
Baker's cyst (synovial cyst or popliteal space)	150.00
Lesion of tendon or fibrous sheath, or ganglion	65.00
Repair or suture	
Extensor tendon, single	
forearm or leg	78.00
hand or foot distal to wrist or ankle	52.00
Flexor tendon, single, finger, hand, or forearm	130.00
Transfer, transplant, or free graft of tendon, single	
Elbow to shoulder, knee to hip	216.75
Distal to elbow, distal to knee	173.50
NERVOUS SYSTEM	
Craniectomy, suboccipital, for brain tumor	650.00
Craniectomy, suboccipital, for section of cranial nerves	541.75

	Scheduled Limit
Craniotomy for drainage of brain abscess	325.00
Laminectomy for removal of intervertebral discs	390.00
Skull, burr holes, one or more, for ventriculography	100.00
Splanchnicectomy, unilateral	300.00
Splanchnicectomy, bilateral	360.00
Sympathectomy, cervical, unilateral	300.00
Sympathectomy, lumbar, unilateral	300.00
Sympathectomy, lumbar, bilateral	380.00
RESPIRATORY SYSTEM	
Antrotomy	
Intranasal, unilateral	70.00
Intranasal, bilateral	108.50
Radical (Caldwell-Luc), unilateral	216.75
Radical (Caldwell-Luc), bilateral	281.75
Bronchoscopy	
Initial	70.00
Subsequent	70.00
With biopsy	86.75
With removal of foreign body or tumor	108.50
Nasal polypectomy	
Single polyp	20.00
Multiple polyps, unilateral or bilateral, one or more stages	40.00
Pneumonectomy or lobectomy	433.50
Tracheotomy	86.75
URINARY SYSTEM	
Cystolithotomy	216.75
Cystoscopy, while resident hospital in-patient	
Diagnostic	50.00
With urethral catheterization	65.00
Cystoscopy with biopsy	50.00

	Scheduled Limit
Excision or fulguration of urethral caruncle	30.50
Pyelotomy, pyelolithotomy, pelviolithotomy	303.50
Removal of kidney	346.75

* * * * *

Schedule of Radiotherapy

This Schedule shows the maximum payments applicable to the respective therapies, including consultation, dosage calculation, materials and the preparation thereof, and the use of facilities. For any therapy neither specified nor expressly excluded, a consistent payment will be objectively determined under the Plan.

Teleradiotherapy	*Maximum Payment*
X-ray—1000 KVP and higher, radium, cobalt, betatron—per treatment	$ 15.00
X-ray—less than 1000 KVP, telecesium—per treatment	10.00
Radium and radioisotope therapy (sealed sources)	
Intracavitary or interstitial application of radium or radioisotope—per treatment	125.00
Application of radium or radioisotope plaque or mold—per treatment	15.00
Radioisotope therapy (non-sealed sources)—administered internally, interstitially or intracavitarily. The maximum stated is for all charges incurred during any 12 consecutive months for the condition shown.	
Thyroid cancer	250.00
Prostatic cancer	300.00
Thyroid ablation for cardiac disease	225.00
Polycythemia vera	100.00

Teleradiotherapy (continued)	*Maximum Payment*
Chronic leukemia	100.00
Metastatic cancer to bone	175.00
Ascites or pleural effusion, or both	250.00
Hyperthyroidism	150.00

* * * * *

Adjustments: If a covered person is disabled on the effective date of an increase in the Medical Expense Benefits, he will retain the same benefits he had before the increase became effective until he is no longer disabled. For this purpose, an Employe is considered to be disabled on any date that he is ill or injured and away from work. A dependent will be considered disabled on any date if he is confined at home or in an institution for medical care or treatment.

Your Weekly Contribution

Refer to Plan Summary (Part I).

PLAINTIFFS' EXHIBIT 11

THE PRUDENTIAL INSURANCE COMPANY
OF AMERICA
Willowbrook Office
201 Willowbrook Boulevard
Wayne, New Jersey 07470

Jeremiah Kelly, F.S.A.
Associate Actuarial Director

October 17, 1972

Mr. Robert A. Bussey
Corporate Insurance Manager
General Dynamics Corporation
Pierre Laclede Center
St. Louis, Missouri

Re: Administrative Services Only

Dear Bob:

A reasonable estimate of the incurred but unreported claims for those health coverages, which changed to an Administrative Services Only arrangement as of October 1, 1972, can be obtained by taking 26.99% of the paid claims for the twelve month period prior to the date as of which you are establishing the estimate.

The factor of 26.99% was determined as of July 1, 1972 based on a study of the actual lag in reporting of claims by your employes under your insured contract for the above health coverages.

Sincerely,

/s/ JERRY
Jeremiah Kelly, F.S.A.

JK:jh
cc: Messrs. Hawkins
Johnson
Zois

PLAINTIFFS' EXHIBIT 12

151 Farmington Avenue
Hartford, Connecticut 06115

James D. Holland
Secretary
Group Division

October 26, 1972

Mr. R. A. Bussey
Corporate Insurance Manager
General Dynamics Corporation
Pierre Laclede Center
St. Louis, Missouri 63105

Dear Mr. Bussey:

You asked that we provide you with factors which you could use to estimate the liability for open and unrevealed claims. We anticipate that we will continue to provide you with quarterly accountings. These accountings will show our estimate of the outstanding liability at the end of each quarter. If it is necessary for you to estimate a change in reserves on a monthly basis, we suggest you use the following factors:

Coverage	*Factor*
Basic Medical	95% of prior three months recorded claims
Basic Dental	109% of prior three months recorded claims
Comprehensive Dental	130% of prior three months recorded claims
Major Medical	188% of prior three months recorded claims

Very truly yours,

/s/ JAMES D. HOLLAND
James D. Holland
Secretary
Group Division
may

IN THE UNITED STATES CLAIMS COURT

No. 7-81T

GENERAL DYNAMICS CORPORATION, ET AL., PLAINTIFFS,

v.

THE UNITED STATES, DEFENDANTS.

(Filed: October 11, 1983)

ADDITIONAL FACT STIPULATION

Plaintiffs, by their attorneys, and defendant, by its attorney, stipulate for the purposes of this proceeding that the following statements of fact are true and correct.

1. Plaintiff's Exhibit 44 is a worksheet which sets forth: (a) the actual 1972 year-end self-insured accrual/reserve for medical care benefits by corporation after adjustments for the extended liability reserve portion and the Aetna drafts outstanding; (b) the 1972 year-end self-insured accrual/reserve for medical care benefits by corporation recalculated strictly in accordance with the percentage figures supplied by the insurance companies with adjustments for the extended liability reserve portion and the Aetna drafts outstanding; and (c) the payments by corporation made in the period 1973 and 1974 on medical care benefit claims which were incurred in 1972 or earlier after adjustment for drafts outstanding.

2. Defendant's Exhibit 21 is a true and correct copy of portion of plaintiffs' 1972 federal income tax return, consisting of pages 1 through 4 of Form 1120 and attached Exhibits 32, 32(a), 32(b), 32-R, 32(a)-R, 32(b)-R, 32-O, 32(a)-O, and 32(b)-O.

TYRONNE E. MCNOWN	J. WALDEN JOHNSON
Attorney for Plaintiffs	Attorney for Defendant

[43]

PORTIONS OF TRIAL TESTIMONY, SEPTEMBER 12, 1983

* * *

JAMES A. HAWKINS

having been first duly sworn, was called as a witness herein and was examined and testified as follows:

DIRECT EXAMINATION

By Ms. McNown:

Q. Would you please state your name for the record?

A. James A. Hawkins.

Q. What is your address?

A. 52089 Fallow, Horseshoe Bay, Texas, 78654.

Q. What is your present occupation?

A. Self employed.

Q. Have you ever been employed by General Dynamics Corporation?

A. Yes.

Q. When did you join General Dynamics?

[44] A. 1963.

Q. What were your positions with General Dynamics?

A. For the first four years I was in the engineering department at the Fort Worth division; for the remaining thirteen years I was in the corporate office in the Employee Benefits Department; the last ten years I was the Director of Employee Benefits, for General Dynamics.

THE COURT: You were in the engineering department, what were you doing there, in what capacity?

THE WITNESS: I worked in the environmental control system design group, and in the administrative side of the engineering department.

THE COURT: Were you an engineer by education?

THE WITNESS: Yes.

THE COURT: I see. Proceed.

By Ms. McNown:

Q. What is your educational background, Mr. Hawkins?

A. I have a bachelor of business administration, and a bachelor of science in mechanical engineering.

Q. You testified that you were Director of Employee Benefits for the last—what?—ten years that you were with the company?

A. Yes.

Q. When did you assume that position?

A. July of 1970.

[45] Q. Okay. What were your duties as Director of Employee Benefits?

A. I had the overall responsibility for the design, the implementation, and the administration of the various employee benefit programs throughout the corporation.

Q. When you say the "corporation" what are you referring to?

A. General Dynamics and the subsidiary companies.

Q. Did General Dynamics and their subsidiaries have medical benefit programs for their employees during some, or all of the time that you were Director of Employee Benefits?

A. Yes, they did.

Q. During what period of that time?

A. All of it.

Q. Had they had such programs for their employees prior to the time you were Director of Employee Benefits?

A. Yes.

A. In future questions I will use the term "General Dynamics" to include General Dynamics and its subsidiaries. Is that acceptable?

A. Yes.

Q. As Director of Employee Benefits, did you have any involvement with medical benefit programs that General Dynamics had?

A. Yes.

[46] Q. What was that involvement?

A. Coordination with the insurance companies; designing the level of benefits; representing the corporation in negotiations with unions concerning the benefits; and various other day-to-day administrative items associated with the benefit plans.

Q. Did you get involved in anyway in the claims handling in relation to the medical benefit program?

A. Indirectly, I did.

Q. What do you mean by "indirectly"?

A. The claims were handled out in the field. Occasionally, we would get feedback from the divisions to make decisions on particular cases.

Q. Would you describe what category of benefits were generally provided by the General Dynamics medical benefit programs?

A. We provided basic hospitalization, surgical benefits, made payments for doctor visits, maternity benefits, dental claims, and we had major medical claims as well.

Q. What level of plans were set forth under the basic medical coverage?

Q. For example we would have a hospital room and board allowance, and a specific amount would be paid for each day of confinement in the hospital. In the surgical area, generally we would have a fixed fee. We would have a schedule [47] of surgical procedures, and show in the booklets how much the plan would pay for those particular procedures.

Q. Under the major medical plans, what level of benefits were provided?

Q. After the employee has satisifed a deductible, which usually was $100, the company would pay 80% of the eligible benefits.

Q. Does that mean the employee paid the remaining 20%?

A. Yes.

Q. So, the General Dynamics plans were not designed to pay 100% of an employees medical expenses?

A. That is correct.

Q. When the medical benefits were insured, did General Dynamics pay anything to the insurance companies?

A. Yes.

Q. What did it pay?

A. Premiums.

Q. Did the insurance companies provide General Dynamics with any information from which General Dynamics could book its medical benefits expense, while the plans were insured?

A. Yes.

Q. What did it provide?

A. As part of the premium structure, there was a factor in there for their reserves and for their retention, [48] as well as their expected claim allowance.

Q. Did they submit any information to General Dynamics for which the corporation could make accounting entries for its medical benefit expense?

A. Yes, they would give us monthly costs per employee. And those cases where dependents were involved, they would give us a separate rate, showing the employee with dependents.

Q. What did General Dynamics do, if anything, with those per employee rates?

A. These rates were distributed to the divisions for them to use in booking their expense.

Q. Did there ever come a time when there was a change in the program, for providing the medical benefits by insurance?

A. Yes, in the fall of 1972, we switched to a self-insurance program.

Q. What do you mean by "a self insurance" program?

A. General Dynamics would assume the liability for the payment of the benefits as opposed to the insurance company.

Q. Once General Dynamics went self insured for the medical benefits, who was liable for the benefits?

A. General Dynamics.

Q. When General Dynamics changed to self insurance, did the type, or the level of the medical care benefits [49] change?

A. No.

Q. Earlier you testified that divisions and subsidiaries used this per person rates supplied by the insurance company to book an expense for medical benefits. After the change to self insurance, was there any change in that practice?

A. No.

Q. After the change to self insurance, did the insurance companies continue to have any role regarding medical care benefits?

A. Yes, they did.

Q. What were those roles?

A. They continued to provide us with the same information they had previously provided us while the benefits were insured. In those cases where they processed claims, they continued to process the claims so there was no change.

MS. McNOWN: Does the reporter have an exhibit 9?

(Pause.)

By Ms. McNown:

Q. Mr. Hawkins, I show you plaintiffs' trial exhibit 9. Can you describe what that is?

(The witness proffered the document.)

A. This is a facsimile of the medical portion of the booklet which we had when we went self insured. In this [50] particular one, it's for the Patternmakers at the Electric Boat Division, with an effectivity of December 1, 1972.

Q. So this plan describes the benefits under the medical benefit program after the change to self insurance?

A. Yes.

Q. Mr. Hawkins, I show you a document which has been marked and received in evidence of plaintiffs' trial exhibit 40. Can you describe that?

A. This is a facsimile of the booklet used for the salaried employees at the Ardmore location—Stromberg-Carlson, Ardmore. And the effectivity is October 1, '72, and it describes the benefits under the self insured program for the Ardmore employees.

Q. What were these booklets, plaintiffs exhibits 9 and 40 used for?

A. To communicate to the employees their medical programs.

Q. Are the booklets which I have shown you, similar or not similar to other booklets provided to other employees at other facilities?

A. Similar.

THE COURT: Now, by other facilities, you mean other General Dynamics facilities?

MS. McNOWN: That is correct. And General Dynamics I have been using the collective sense of the corporation and [51] the subsidiaries.

THE COURT: All right.

MS. McNOWN: It has been stipulated, Your Honor, that the booklets are, indeed, typical of the booklets distributed at the various facilities.

By Ms. McNown:

Q. Mr. Hawkins, while self insured did General Dynamics make any promises to the employees about providing medical benefits?

A. As part of their employment, I think there was implied promise that we would provide benefits to them.

Q. Specifically, what was that promise?

A. That if they were eligible and had expenses for benefits covered under the plan, that we would pay for them.

Q. Under the self insured medical plan, at what point did the liability for medical benefits become fixed for General Dynamics?

A. At the time the service was rendered.

Q. Was General Dynamics liable to pay for the medical benefits even though a claim form had not yet been filed?

A. Yes.

Q. Under the terms of the plan, if an employee received covered medical services in say, January, and his employment terminated in February, and he submitted a claim in March for his January expenses, did General Dynamics have [52] to pay for those benefits?

A. Yes.

Q. Even if a claim had not been filed until after the employee was no longer employed?

A. That is correct.

Q. Why?

A. Because the service had been rendered at the time the employee was – at the time the person was an employee of General Dynamics. Therefore, we had a liability for those benefits.

Q. Under the terms of the General Dynamics plans, if a covered dependent, say a student, received covered medical expenses in January, then graduated and went out and lost his covered status in February, and a claim was submitted in March for the January benefits, did General Dynamics have to pay for those benefits?

A. Yes.

Q. Why?

A. Because the service was rendered while the dependent was eligible for benefits.

Q. Under the terms of the plans, if General Dynamics terminated its program of medical benefits, could it refuse

to pay for claims for services which had been rendered to covered employees, prior to the termination of the plan?

A. No.

[53] Q. Why not?

A. Because the service was rendered while the employee was eligible.

Q. Under the General Dynamics plans, if a person who was not an employee, received medical services in say, June, and he becomes a General Dynamics employee in July, and in August he submits to the corporation a claim for those June expenses which he had received before his employment, would those expenses be paid?

A. No.

Q. Why not?

A. He was not eligible when service was rendered.

Q. From your work in the employee benefits department, were you familiar with the processing procedures for handling medical benefit claims?

A. Generally.

Q. Would you please describe, generally, the process for handling medical benefit claims for plans administered by the Aetna Insurance Company, when General Dynamics was self insured, in the latter part of 1972?

THE COURT: Let's go off the record a second.

(Discussion was held off the record.)

THE COURT: On the record.

By Ms. McNown:

Q. Mr. Hawkins, would you please describe generally, [54] the process for handling medical benefit claims for the plans which were administered by the Aetna Insurance Company after the change to self insurance around 1972?

A. Typically an employee would present a claim to the local employee benefits office at his or her respective location. The employee benefits office would verify eligibility for benefits.

Q. What do you mean by "eligibility"?

A. To see if the person submitting the claim was eligible to receive benefits. The employees benefits office would in turn forward this claim to the local Aetna claim office and the Aetna claim office would then calculate the benefits to be payable, and issue a check to either the employee, or if the employee had assigned benefits, we'd send the check directly to the hospital, or doctors involved.

Q. What do you mean by assigned benefits?

A. Rather than have the insurance company send the payment for benefits directly to the employee, the employee can, and usually can designate on the claim form that he would like to have the benefits assigned, which means that the payment will be made directly to the hospital or doctor.

Q. Is any material sent to the employee besides the check?

A. Yes, there is a claim payment form which shows the calculation of benefits; shows which benefits were paid; [55] and if they were benefits which were not eligible, it would also show that. It would give the employee the understanding as to what happened to his total claim.

Q. Would you generally describe the processing for medical claims for plans which were administered by the Prudential Insurance Co., around 1972, when the plans were self insured?

A. In those cases, the employee would submit the claim to the employee benefits office at the local division, and at most of the Prudential locations our own people did the calculation of benefits so they would physically have the claim in hand, and do the calculation, and send the information payment and the claim payment form back to the employee, or the hospital or doctor, directly. We did have a few locations where the Prudential processed the claims for us, because we were not staffed up, or didn't have the expertise to do that ourselves.

Q. Would you describe the degree of difficulty for company personnel in determining whether or not an employee or dependent was eligible for benefits under the plan?

A. It would be a fairly simple clerical procedure to match up the name against the payroll roster.

Q. What happened if an employee did not like, or understand the amount that had been calculated as his paid benefits?

[56] A. He would go to the employee benefits office, and seek clarification as to why something was done.

Q. And if he was satisfied with that explanation, that would be the end of it?

A. Yes.

Q. If he wanted additional explanation, what happened?

A. If he didn't agree with the information given to him by the local employee benefits office, he could have the local benefits office refer the case to the corporate headquarters for them to review it.

Q. And by the "corporate headquarters" would that be you and your staff?

A. Yes, that is correct.

Q. How large was your staff back in 1972?

A. In 1972, I believe we had only two people, in addition to myself, at that time.

Q. How frequently during the course of the year, would you or your staff have to act on—what? Appeals?—the handling of medical benefit claims?

A. Twice a month, maybe thirty times a year, or so.

Q. And that would be for all of the plans that General Dynamics had?

A. Yes.

THE COURT: How many people would be covered by all the plans?

[57] THE WITNESS: Oh, we're talking maybe 80 to 100,000 employees.

THE COURT: Okay.

By Ms. McNown:

Q. Did you, yourself get involved in decisions regarding individual claims?

A. Occasionally, yes, I did.

Q. In your experience were there many lawsuits resulting from the denial of medical benefit claims?

THE COURT: During what year?

MS McNOWN: In general.

By Ms. McNown:

Q. In 1972?

A. I don't believe that there were any.

Q. In the years that you were Director of Employee Benefits, what was the incidence of lawsuits resulting from the denial of medical care benefits?

THE COURT: And what years were these again, that you were Director?

THE WITNESS: 1970 to 1980.

THE COURT: Okay.

THE WITNESS: I don't believe we had any.

By Ms. McNown.

Q. Why did you have such a low incidence of lawsuits on medical care benefit claim denials?

[58] A. I think for the most part that the employees were happy with their benefits, and a very, very large percentage of the actual bills was paid, so that out of a $1,000 claim, with a major medical program you can usually figure that at least $800 is going to be paid, and in most cases, I would say that the payment exceeded 90% of the actual bill, so they were happy with the results.

THE COURT: How could the payment exceed 90%, when there was testimony earlier that only—that the agreement was just to pay 80% of the bill?

THE WITNESS: When you have a basic and major medical plan, there's some benefits that are paid under the basic—the 80% would not apply in that case.

THE COURT: So, under the basic you are testifying that General Dynamics paid 100%?

THE WITNESS: Not necessarily 100%, but over 80%. If a person went into the hospital and had a room and board charge, and we had an allowance for room and board at that time at, say about $60 a day, but the room charge actually exceeded $60. The excess would go over into the major medical plan, and after satisfying the deductible, it would be paid at 80%. Now, if the hospital only charged $60, then it would be paid at 100%

THE COURT: I see.

THE WITNESS: So you could have a situation where [59] the basic would be paying close to 100%, and then you could have other situations where the basic would pay fewer dollars but the excess would go over into major medical and be picked up there at 80%. But in total, generally speaking, you could expect at least 80% of the claim to be paid, if you had a major medical program.

THE COURT: All right. Proceed.

By Ms. McNown:

Q. Are all of the medical benefit claims denied, until they are paid?

A. No.

Q. At what point in the processing of a claim is a claim denied?

A. Only after the processing is complete and it is determined that denial is in order.

Q. Were the employees of General Dynamics informed that the General Dynamics plans would pay part of their medical bills, but not 100%?

A. Yes.

Q. And how were they told that?

A. Through the employee booklets given to them, which set forth the plan of benefits, the levels and the schedules.

Q. Was there any philosophy in the 1972 time period, regarding the administration of the medical benefit plans?

A. I would say that if there were any questions, we [60] generally would give the employee the benefit of the doubt.

Q. Why?

A. Simply to promote good employer-employee relationships.

Q. You testified earlier that approximately thirty times a year, employees would ask for the corporate office to consider the action taken on their medical benefit claims. Is that statistic true for the whole period that you were medical benefits director? The approximate 30 times a year?

A. I would say so.

Q. In your experience, what percentage of medical benefit claims are filed within three months of the incurral of the claim, that is, the rendition of the services?

A. I would say most of them—90%.

Q. Were any of the medical benefit plans the General Dynamics had provided to union employees?

A. Yes.

Q. Were the level of benefits and the types of benefits subject to collective bargaining with those unions?

A. Yes.

Q. To change the benefits provided under a plan for union employees, would General Dynamics have to negotiate such a change?

A. Yes.

Ms. McNOWN: That's all I have on direct, Your [61] Honor.

THE COURT: All right. At this time, the Court is going to stand for a luncheon recess, and let the defendant gather its thoughts for cross.

We'll come back at 1:30.

(Whereupon, at 11:48 a.m., the hearing was recessed to reconvene at 1:30 p.m., this same day, Monday, September 12, 1983.)

[62]

AFTERNOON SESSION **1:27 p.m.**

THE COURT: Please be seated. Off the record.

(Discussion was held off the record.)

THE COURT: (Back on the record.) We're ready for defendent's cross of Mr. James A. Hawkins. Mr. Hawkins, you are still under oath and sworn to tell the truth. Will you take the stand, please.

Whereupon,

JAMES A. HAWKINS

having been previously duly sworn, was recalled as a witness herein, and was examined and testified further as follows:

CROSS-EXAMINATION

THE COURT: Defendant may proceed.

MR. JOHNSON: Thank you, Your Honor.

By Mr. Johnson:

Q. Mr Hawkins, let me ask you; you mentioned earlier this morning that in your opinion the, or you were liable to reimburse a worker for medical services received, once that worker had received those medical services. Why is that so?

A. Because we communicated to the employees that they had a certain plan of benefits, and once the employee went to the doctor, or hospital, and had those services rendered, it would be our position that we would have a liability to make payment for those benefits.

[63] Q. What if the worker who received those medical services was injured while working on the job? What would happen in that circumstance?

A. Well, that would be a Worker's Comp case then.

Q. And so then, would that worker receive reumbursement under your medical plans?

A. Not if he were covered under Worker's Comp.

Q. What if that worker was injured while on a weekend in the Army Reserve? Would he be under your medical plan?

A. I would say yes, subject to any coordination with CHAMPUS, if that applied.

Q. Would you have any instances where—or, were there instances when a worker received medical services and filed a form and yet was paid zero?

A. Yes, if the worker were not eligible for benefits, we may go ahead and process a claim but because of ineligibility no benefits would be paid.

THE COURT: You're not saying the worker, himself, would process the claim? He would file the claim and you would process it?

THE WITNESS: Yes.

THE COURT: All right. Proceed.

By Mr. Johnson:

Q. Were there any other instances where the worker would receive zero?

[64] A. (No response.)

Q. I think one we mentioned was the worker was injured while on the job, and was under Workmen's Compensation. Would there be any others?

A. I can't think of any off the top of my head right now.

Q. What if it was a new employee and the injury had arose before the time that the worker was an employee of the taxpayer?

THE COURT: Are you saying "injury" as distinct from a disease?

MR. JOHNSON: Yes.

THE COURT: All right.

THE WITNESS: You're wanting to know if benefits would be paid from the General Dynamics medical plan?

MR. JOHNSON: Yes.

THE WITNESS: Not if he were covered under Workmen's Comp.

By Mr. Johnson:

Q. And what if you had a person who was injured on November 9, say, and then was a new worker of the taxpayer on November 15th, and then was in the hospital on November 19th, would he be reimbursed for the services he received on the 19th of November?

A. He was injured before he became employed?

[65] Q. Yes.

A. No.

Q. What would happen when the medical services that the worker received, had a recognized value of less than what was charged?

A. I'm not sure I understand that question?

Q. What would happen if you had a worker who was in the hospital and he had a broken hand, and the hospital charged him a very, very large amount for his medical services. Would he be reimbursed that whole amount?

A. He would only be reimbursed whatever the plan of benefits called for, for the particular hospital stay or surgical procedure. If the amount that was charged was more than what the plan paid, then obviously, the company wouldn't pay 100%.

Q. When would you know whether the medical services that were received in the amount that was charged, was more than what was allowable under the plans?

A. Once the claim had been processed.

Q. What would happen if a worker was injured, received medical treatment and never mailed in a form? In other words, never sought reimbursement.

A. As far as the medical plan of General Dynamics is concerned, there would be no action taken because there would be no claim submitted. And plus, if he was covered by [66] Worker's Comp, again we'd have no liability to pay him.

Q. When you have a worker that was injured and on the job, when were you liable to pay for their medical services?

Then that would be under the medical plans rather than worker's compensation?

A. If worker's comp didn't apply, we would be liable at the time that the services were rendered, and we would have an obligation to pay those benefits regardless of when the claim came in.

THE COURT: You wouldn't be liable when the injury occurred?

THE WITNESS: Yes, we would.

THE COURT: That's not what you said. You said you would be liable when the services were rendered. Do you wish to change your testimony?

THE WITNESS: As far as the medical benefits are concerned, once the employee goes to the hospital, or doctors, and receives services, liability attaches at that point.

THE COURT: All right, then, you're not liable once the injury occurred—at the time the injury occurs on the job? Is that your testimony? Do you see the distinction?

THE WITNESS: Well, I'm confused, because he is talking about a worker's comp versus the medical program.

THE COURT: All right. Why don't you repeat that question so we can get it straight for the record?

[67] *By Mr. Johnson:*

Q. All right. You have mentioned earlier that you were liable under the medical—the non-worker's compensation, the medical plan—once the medical treatment was conceived.

A. Yes.

Q. What would happen if the injury that resulted in receiving medical treatment was upon the job injury? When would you be liable, then?

A: From what standpoint? From a worker's comp standpoint—

Q. Non-workmens comp—the medical plan?

A. I would say that once the person that received the injury went to the hospital emergency room or whatever, if the worker's comp program didn't pay for those services, then we would be liable at the time those services were rendered.

Q. And what would happen if it was under workmen's compensation?

A. Then we wouldn't be liable because the benefits would be paid under the worker's comp program.

Q. When would you find out whether an injury had happened on the job?

A. I would say, the day that it happened.

Q. Was that information on the form that the worker sent in?

A. There is a blank on the form that asks if the [68] injury is work related.

Q. When would you know that the medical treatment that a worker had received was reasonable or not?

A. Reasonable from what standpoint?

Q. A reasonable charge.

A. We would know the amount of the doctors fee and the hospital bill upon receipt of the claim form.

Q. What if you had a worker who walked in and he mentioned that he was in the hospital last week and he had to pay a certain amount of money, and he wanted his money right then. Would he be reimbursed?

A. Assuming he were an eligible employee for benefits we would ask him to file a claim form, and submit a claim, and it would be processed.

Q. Would he be reimbursed if he filed no form?

A. No.

MR JOHNSON: That's all the questions I have.

THE COURT: All right. Redirect?

MS. McNOWN: Could I have one minute, Your Honor?

THE COURT: All right.

(Pause.)

REDIRECT EXAMINATION

By Ms. McNown:

Q. Mr. Hawkins, if an employee was injured on the job during the day, would there be a report filed normally by [69] somebody at the company that day?

A. Yes.

Q. So you would know the day that a job accident occurred that an employee had been injured that day?

A. Yes.

Q. If an employee went to the hospital and was charged an excessive fee for a surgical procedure, and a claim processor was at the hospital and looked at the bill that was rendered to that employee, on the day that the employee got the bill, would the claim processor be able to determine that that fee was excessive?

A. Yes.

Q. If a General Dynamics employee is injured and is covered under the workmen's compensation plan, those same medical benefits—or, the medical charges which are in relation to that workmen's compensation claim are not also covered by the medical benefit plan, is that correct?

A. Yes.

MS. McNOWN: That's all I have on redirect, Your Honor.

THE COURT: All right. Recross?

MR. JOHNSON: No, Your Honor.

THE COURT: Hearing that there are no further questions of this witness, this concludes the testimony of Mr. James A. Hawkins. Thank you very much, Mr, Hawkins, for [70] your testimony in this matter. You are now excused from thi Court.

(The witness was excused.)

THE COURT: Plaintiff may now call its next witness.

MS. McNOWN: Plaintiff calls, J. David Loftus. Whereupon,

J. DAVID LOFTUS

having been first duly sworn, was called as a witness herein and was examined and testified as follows:

THE COURT: Plaintiff may proceed.

DIRECT EXAMINATION

By Ms. McNown:

Q. Would you please state your name?

A. J. David Loftus.

Q. What is your address?

A. My address is 105 Deborah Drive, Coventry, Connecticut, zip code 06238.

Q. By whom are you employed?

A. Aetna Life Insurance Company.

Q. What is your current position?

A. I'm administer in the Group Claim Department.

Q. How long have you worked for Aetna?

A. Twenty-three years.

Q. Where is your office located?

[71] A. Currently our home office is located in Hartford, Connecticut. That's where I am now placed.

Q. How long have you worked in the insurance business?

A. For 23 years.

Q. So your whole insurance career has been with Aetna?

A. That is correct.

Q. Are you a college graduate?

A. Yes, I am.

Q. What was your major?

A. I have a bachelor of business administration, major in management.

Q. Briefly, would you please tell us what positions and duties you have had with Aetna, and the periods that are involved?

A. I was hired on July 18th, 1960, in our Rochester Group Claim Department as a claim representative. For a period of ten months, I was employed as a claim representative. My primary function was to investigate long term and short term disability claims, and to assist the processor in interpreting contracts, and the claims that they had—additional information. I then went into the government service in the army for a period of six months, at which time in December of 1961, I returned to the employ of Aetna; this time in Hartford, Connecticut as a claim examiner. The function of the claim examiner was to review those special [72] claims submitted to them by our field offices, which needed assistance. I worked there fifteen months, at which time I was promoted to an assistant supervisor to our Lansing office, which at time was in charge of the plan for the Michigan Department Civil Service. My job as supervisor was to assist the processors on the day-to-day handling of group claims.

I stayed in Lansing for a period of ten years, at which time the operation grew from six people to 72 people, as the plan also grew. When I left there in 1973, I was a supervisor, which today is translated as a claim manager.

I was transferred to the home office for purposes of establishing a planned program which would help us educate our processors in the handling of a dental claim. The dental business was growing very rapidly. We had a new plan of benefits and we were trying to teach the employees by themselves. This was an innovative task of self management and self teaching. We completed that work in about ten months at which time I was promoted to superintendent of the government-wide Indemnity Benefit

Plan, for which I am still in charge. But, later on, in 1982 of this year, my duties were expanded to include the northeast and the southeast region of our claim business, which encompasses ten regional offices.

I am responsible for the government life plan, those regional offices, and any aspect of claims which need [73] further review or assistance in our home office.

Q. You said in February of this year, 1982—

A. This year, 1982—I mean 1983. I'm sorry, yes.

Q. The claims work that you have done over the years what kind of claims has that been involved with?

A. It has been involving all aspects of group claims, life, temporary disability, weekly disability, long term disability, primarily medical and major medical, and vision and dental care.

Q. The current function that you have as claim administrator in the home office, what are the duties of that position?

A. As claim administrator, our function is to assist in both developing and disseminating information, such as, guidelines, interpretations, general procedures to all of our field offices, and on an individual claim basis, to respond to any claim need they would have, such as; if the operation that was performed was in question as to what actually occurred, we would use our resources in the home office, which of course would be our medical department, to actually review the operative report so that we could ascertain that the benefits that we were suggesting were available, were indeed available, and an additional amount wouldn't be due, or that there were no extenuating circumstances. That plus trying to keep abreast of the medical practitioning and the [74] medical community, as far as introducing new procedures as to what would be covered under the plan; as determining whether or not it is now considered a covered expense versus an investigational or experimental. This is all the realm of the home office maintained in Hartford.

Q. How large a staff do you have?

A. Currently I have nine people as examiners, but the examining units in the group claim department have eighteen people.

Q. How many medical benefit plans do you and your staff work on?

A. Besides the government-wide indemnity benefit plan, and a few target accounts, we literally have thousands within that northeast-southeast region.

Q. Has your experience, for the whole time that you have been with Aetna, related in part to medical and dental benefits?

A. Yes.

Q. It has been stipulated in this case that General Dynamics and its subsidiaries had insured some of their medical care plans with Aetna in 1972 and prior years, and that they changed to self insurance in the later part of 1972 for those medical care benefits.

Mr. Loftus, are you familiar with the methods and procedures used by Aetna's claim personnel in processing [75] medical benefit claims in the period around 1972?

A. I am.

Q. Were the methods and procedures that Aetna was using for processing medical benefit claims different if the claims were self insured, rather than insured?

A. No, they weren't. Actually, self insurance is transparent to the claim department. It's a reserve or financial arrangement.

Q. So the same policy and procedures would be used by the claims processing staff?

A. That is correct.

Q. So General Dynamics claims when they changed to self insurance would be processed the same by the Aetna claims processors as before the change, itself, occurred?

A. That is correct.

Q. Would the same claims offices at Aetna and the same personnel handle the General Dynamics case when it changed from insurance to self insurance?

A. Yes. They are the same people.

Q. Was there a particular department or division within Aetna that did the processing of medical benefit claims during the 1972 time period?

A. The Group Claim Department was responsible.

Q. Would you briefly describe the internal organization of the Group Claim Department in relation to [76] medical benefit claims?

A. Group Claim Department is primarily two functions; one is the home office, and that is where all of the data is kept in storage, and the claim department there, provides the raw material and resources to the field offices. The field office, on the other hand, has the responsibility of the hands-on payment of claims that they receive everyday.

The home office, therefore, is the instructional office. They provide manuals, the education, they also provide a resource on the review of any individual claim.

Q. And the actual processing of a claim is handled in the field office?

A. In the field offices, themselves, that is correct.

Q. You, in fact, operated a field office, is that correct?

A. Yes, in Lansing, Michigan.

Q. Would you briefly describe the qualifications and training of personnel who did the claims processing work, in the Aetna field offices?

A. Generally, the claim processor was female, age 20, with a high school education and one year of college, or the equivalent in the business field. These people were hired by us and trained.

The training period usually lasted six months, where we would start off with a basically easy claim, such as [77] hospital and surgery, and slowly, but surely, develop their expertise over a period of six months. During this period of time, they were under 100% supervision and audit in order for that work to be delivered outside of their unit.

At the end of that six month period, however, they are well versed in the handling of basic major medical coverages, the insurance product itself, the general description of our insurance coverages, and also coordination of benefits, and the general exclusion that should apply to a contract.

Q. All right. Besides these processors who are trained, and then who are at the lower level of processing, are there other people in the claims office or regional office who are involved in processing medical claims?

A. Yes. At the end of six months, these people would be assigned to a regular group claim processing unit. They were made up of anywhere from four to eight people. They were supervised by supervisors, and a supervisor reported to a manager or assistant manager in the office. There was a natural line of review there.

If the claim processor found that any of the claims exceeded the guidelines or even their expertise, they had the responsibility of calling that to the attention of their boss, who in turn used additional resources and, of course, the expertise to try to resolve the claim. There was also that person could utilize the assistant manager who [78] again had four to six years of experience in the handling of claims. If that particular claim could not be resolved at that point, they had the option of either—if it was a medical question, of either utilizing local peer review or medical consultants or of course, the home office. If it was a question of interpretation of the contract or what benefits should be paid, they would utilize the home office for interpretation.

Q. Would you describe the type of—or categories of benefits that are provided under a basic medical benefits plan?

A. Yes. First of all, by basic coverage, this is a coverage that allows benefits up front without any deductible or co-insurance. So, under our basic plan, the obvious coverages would be hospital, surgical, medical,

anesthesia benefits, and these benefits were payable and were available readily, without any deductible.

Q. Would you describe the types or categories of benefits provided by major medical plans?

A. A major medical plan was really devised as an umbrella, or major expenses. These expenses took into consideration those that might already have been available under the basic plan, but it also included a further scope of coverage; such things as, registered nursing services were covered under major medical, so, too, were prescription drugs [79] that required a prescription from a doctor in order to be obtained. These charges would be not available under basics, so therefore, after a calendar year cash deductible, generally $100, were reimbursed at 80%.

Q. Who pays the other 20%?

A. The other 20% was called the employees share, and the employee was responsible for that.

Q. All right. I would now like to go through the procedures used in processing the medical benefit claims in the 1972-1973 time period.

What is the first thing that happens in the work flow in Aetna regional claims offices—field office?

A. The first thing we would receive is the claim form which was submitted to us via the contract holder, General Dynamics. General Dynamics' responsibility at that point, would have been to take these bills from their employee, and attach to it a certification from which told us at Aetna, that these benefits would be available in accordance with a particular plan, for instance, as we discussed here this morning. The plans maybe different, depending on the subsidiaries. The processors would need this information later on to compute these benefits. The plans varied. Therefore, once we receive that in our office, we knew the individual and the type of plan and the specific plan they belonged to and the fact that they were covered under the

[80] plan, and we would be given the effective date of coverage.

Q. Okay. So, when the claim comes to Aetna, the eligibility of the claim, then, is already established?

A. That is correct.

Q. Once a claim form comes to the Aetna office, with that certification, what happens?

A. Once our claim office received it, we would open the mail and identify the plan, alphabetize it—all of the records that were in that envelope, we would then, through the administrative services, arrange to have any existing file that we might have for that family and family members be associated; that would be combined with the new or the write-in claim. That information would then go to the claim processor.

Q. Now you said you'd see that a file was "associated" what do you mean by that?

A. Right. By a file being associated, that at the Aetna, we had separate folders for every employee of General Dynamics and all of our businesses. This way, we had to relate to existing conditions, and sometimes these claims were ongoing. So, we would have to take into consideration what we have already paid, so we would avoid a duplicate payment. So all of that information was prepared by the administrative staff for the processor at the time that she wanted to process the claim.

[81] Q. So you maintained continuing files on employees and then pulled them when new claims came in?

A. That is correct.

Q. You said that the claims are alphabetized?

A. Yes.

Q. Why are they alphabetized?

A. They would be alphabetized for the facility, because certain units because of their size would handle a certain section of the alphabet of the large policy holders

like General Dynamics. For instance "A" through "L" might be the unit No. 1, so, and also it made it easier on the administrative staff to actually keep track of these manual files.

Q. So for a client as large as General Dynamics, certain processors would handle a certain segment of the alphabetical group of employees on an ongoing basis?

A. That is correct. Now, this was needed because we would try to put all of one plan into one or two processors hands, so that they would become familiar with the plan and reduce the possibility of error, or misinterpretation.

Q. All right. Once the file is pulled and prepared, what happens next? It goes through the process?

A. It goes to the claims processor. The claim processor at this point is looking at the bills incurred by the employee. He is looking also at the certification form [82] from the policy holder, the contract holder, and verify the individual, and verify that the bill is being presented were not previously submitted, and now he is pulling out what we refer to as a brief card. It gives a bird's eye overview of exactly what is the coverage. For instance, the brief card would tell us that there is a hospital benefit available. It would not describe in detail what the benefits are, other than saying we'll pay room and board at $60 a day. We will pay for 31 days of hospitalization. We'll pay miscellaneous fees of $1,000. That would be the sum total of information on that card. But that information was also available for surgery, anesthesia, medical, major medical. It would give us all of the pertinent information we possibly would need in order to process a claim. For instance, let's suppose that we receive a claim for a simple case of an appendectomy. By the time the processors look at that claim, we would have a hospital bill an anesthesist bill, a claim from the surgeon. We would even have perhaps even an ambulance bill. We would probably have a goodly amount of prescription drugs. The processors job

then, was to identify the plan and establish a definite amount as to what could be paid under the plan. For instance, under the room and board charges for the hospital. The processor was trained to take the hospital bill and physically divide it into three areas; number one, the room and board. The room and board benefit would show [83] the number of days confined, multiplied by the amount that we could pay. So, in this fashion we were able to develop the basic benefits available for hospital. The same for the miscellaneous fees. The miscellaneous fees are charges by the hospital that are not room and board. And the third category of charges that we would have would be those charges that we couldn't pay at all, such as television.

But by displaying it on what we call an explanation of benefit payment form, we would be taking and reporting to the employees, exactly what he gave us; hospital bill, dates incurred, amounts submitted; then we would show him how we would separate the bill into hospital room and board, and miscellaneous fees and non-covered items. And in the next column we would show what could not be covered, and we would explain by comment, why. The last column we would be showing him what we are paying under the first dollar benefits under basic, and from the third column subtracted from the first column, anything remaining went toward the major medical. The same theory went all the way through for the rest of the claim. Under surgery, for instance, the doctor might have charged $500. Under the particular schedule, $400 would be the basic benefit. So, $500 would be in one column; $400 in the next and a $100 balance went to the third column. as far as major medical.

Q. Okay. And once they have grouped this on the [84] explanation of benefits worksheet, payment sheet, what do they do after they have made those?

A. Okay. Once these categorizations are made, that is the first step towards identifying how the benefits are going to be made. For instance, for the hospital benefit, we would issue a draft generally to the hospital because most of them had a hospital assignment, a notice to us from the employee, please pay them directly, and we would issue at the bottom, notification that this benefit payment is going to the hospital for the hospital's portion. The same would be for the surgeon's portion. They were assigned too, generally. We would pay the doctor directly. The anesthesia, perhaps, could be assigned. But if we are talking about prescription drugs, there is no basic benefit for that. The remainder would have gone under major medical. So, when you come to major medical, you're talking about all covered expenses subtracted from that what was available under basic, and subtracting from the remainder on a calendar year basis, a hundred dollars. The remainder was paid at 80%. Those benefits generally went back to the enrollee, or employee, himself, because it was for usually the type of expenses were not generally assigned.

Now, this information, once it was displayed on the work sheet, it was tattletale to everyone, both the employer, the Aetna, and the employee, exactly how we took [85] those bills and processed them. It was also tattletale to our clerical unit, to actually issue those drafts based upon that certification.

Q. So once the processor has been through the claims file and noted the charges that are going to be paid and calculated them; the checks are written to the appropriate people, is the employee given—what? A written explanation?

A. Yes. Right, gets a copy of the written explanation. The policy holder gets a copy. And, back in those days, we also sent an actual copy of the draft along with the employee's so he could actually see where these monies are going.

Q. Okay. What you've just described sounds like a relatively trouble free type of case. What percentage of claims fall in that category?

A. We would figure that anywhere between 94-95% of the claims would be routinely handled in that fashion, because of the plan design and the specific and certain ways of being able to take exactly what was available.

Q. And for this type of a claim, who in the regional office would be involved in calculating and processing that claim?

A. Those claims would be paid by the processors, themselves.

Q. Would a supervisor have to get involved in those [86] 94% of the cases?

A. No, not at all.

Q. So the supervisors at the regional offices get involved in what per cent of the cases?

A. Anywhere from 5-6% of the claims.

THE COURT: Is there a money limit that the claims people can pay out?

THE WITNESS: Yes, Your Honor. There is a definite limit for each job description. The younger would have a $5,000 limit; where the supervisors would have $10,000, back then, and the manager, of course, had plan limits.

MS. McNCWN: Okay.

By Ms. McNown:

Q. Of the group of claims that supervisors might get involved with, that you said 5-to 6%, how many of those would require—now, the supervisors in a regional office, is that correct?

A. That is correct.

Q. How many of that 5-to 6% of claims would require input or consultation from the Aetna home office?

A. About 1% of what they reviewed, was reviewed by us.

Q. One per cent of . . .

A. Of their 5%.

Q. Of their 6%, or 1% of all claims?

A. No, 1% of their 6%.

[87] Q. Okay. So we're talking not about 1% of the total claims, but 1% of the 6% that the supervisors work on?

A. That is correct. That's right.

Q. Why is Aetna able to process such a large portion of the claims without supervisory review?

A. Primarily, it in on plan design. Secondarily, it is because of the education that the processors are actually receiving, and the fact that most of the procedures they are looking at, is mimicking exactly what exists in nature. We know what the doctors are going to do for a tonsilectomy, and what it is going to look like. We see what the hospital bills are, and we are very easy to instruct these people as to how to recognize the portion that is covered and to the extent that it is.

Q. Would you list some of the categories of claims that would require a supervisor's review?

A. Right. Primarily, I think it would be easier if we wnet down the line of coverage. For instance, if we were talking about a hospital bill, what would a supervisor be looking at? A supervisor would look at a hospital bill, if in the case of the appendectomy—we would know that an appendectomy usually requires a confinement of five days. If there was a confinement of ten days, the processor would say that that appears extraordinary, and why? The supervisor would have to look at that claim. Under the surgical portion, [88] the processors are very familiar with the charging patterns for specific procedures and if there was an excessive—an outlandish difference between what they were normally used to seeing, they might ask the supervisor for instructions.

Of course, there are now and then, new procedures that are introduced, that are not even in our schedules, even the

one that we publish in the home office, and this requires supervisory review and also perhaps home office involvement, to determine is this generally a covered procedure? Is this generally accepted in the medical society?

Q. Okay. If a claim comes in, for example, a surgeons bill which is considerably greater than what the processor knows to be the fees charged for that procedure, what happens to that claim?

A. That claim—I think what we should do again—I hate to use examples, but it is easier for me—if we were to look at the example of the appendectomy, let's suppose that the going fee is $500. Our processors, being in a region, are very familiar with the charging patterns within that region, so they are able to quickly spot an exorbitant amount. So in the case of a $500 fee, $550 would not be deemed exorbitant, but $1,000 would. The first reaction that our processor would have, is that there is not enough information to handle that claim. So the processors would go and seek additional information, or instruction from the [89] supervisor.

Q. Why does the processor say there isn't enough information to handle the claim?

A. Because, arbitrarily you would think that if $500 was the going rate, we should just automatically deny the balance of $500. We have certain rules and regulations among the paying of a claim that will show, or clue in the processors of what is exorbitant, and if the fee that we are paying is generally 20% higher, than what we consider normal, that is a clue to the processor that something is lacking. In the case of the appendectomy, there have been occurrences where the records that we received showed appendectomy, when really we were talking about a gall bladder, too. But, this information then is gleaned by the claim office. The processor would call the doctor's office for a quick check to say, "Are you sure that is all it was?" And, if they were certain that the doctor was right, that

what we got was sufficient, we would still have to get the operative report, to send it into the home office for a medical review, because we would not be able to just routinely deny that exorbitant fee, in that example, as "I'm sorry, it exceeds our normal fee. There is something missing on that charge. The supervisor would look at it to determine what that particular doctor—normally charged $1,000. Now, if that's the case, then we would have a certain position that we would have to take; [90] notably, $400 was covered under basis; $500 is allowed under major medical, and the $500 difference is what the doctor has charged is just not covered under your plan.

Q. If the request for information from the doctor shows that a gall bladder removal was involved at the same time an appendectomy was performed, what is the claims processing response to that?

A. Okay. The claims processing responsibility is to further document that file with the fact that they did check with the doctor's office and here's the additional evidence that came in. Each file has got to stand on its own merits. So, with that, the processor is instructed to so put that information into the file and it is that information that we are allowing to show our auditors as well as those from the contractor holder, as to what we used in order to accept that entire fee.

Q. So, if you see that additional procedures were performed, you would pay a higher fee than what the bill had first looked like?

A. That is correct.

Q. Or, was called for?

A. That's right.

Q. How was Aetna able to determine what a proper surgeons fee is for a procedure like an appendectomy?

A. The processors have available to them, a printout, [91] which is labeled obviously, the prevailing fee printout. By prevailing fee, I mean that in a certain geographic area

which we call medical expense area, for instance, St. Louis is a medical expense area. For a tonsillectomy, because a tonsillectomy carries a certain CPT code—Common Procedure Terminology—it is a five digit number. It locks right into the fact that by our computer, this is the code for an appendectomy. We then put into our computer the fact that the doctor is practicing in St. Louis by his zip code, so that when we see all of the claims coming from St. Louis for an appendectomy, this information going into our computer, is then allowing us to produce a report that will tell any of the processors involved in the St. Louis area, precisely what the prevailing fee is. Again, prevailing means what most doctors are charging.

Q. How do you establish prevailing?

A. Prevailing? Prevailing establishes itself. We see that prevailing to be what most doctors would charge, and generally you are seeing something falling at a percentile of between 75-and 85%. Let me see if I can further explain that. Of all the charges in St. Louis for a tonsillectomy going into our computer, we are reporting precisely what the doctors are charging. This information then is tallied in a percentile; 5, 25, 50, 75th, 85th, 95th and 100 percentile, so that we see all of the charges displayed and we have an [92] actual falling where the most doctors will charge at or below.

Q. And what is the dividing line, I gather that you use?

A. The dividing line is the bulk of the physicians. So, in some instances, a prevailing fee may be the 75th per cent. A prevailing fee on the other hand might be a 95th per cent, but the preponderence of them fall at or below the 85th percentile.

Q. Now when you say it falls at the 85th percentile, that means you are paying—

A. 85% of the claims that we receive for doctors in St. Louis, for that procedure, at that level or below. Of

course, if they charge less than that level, we'll accept that as the covered expense.

Q. Okay. If a claim comes in—so Aetna is actually collecting on an ongoing basis the information as to what doctors in a geographical areas are charging for a particular procedure?

A. Yes.

Q. And was it doing this in 1972?

A. We had started to.

Q. Now, did Aetna also collect information regarding what individual doctors were paying?

A. We do today, but we were not—that information was not available to us as readily in 1972.

[93] Q. How does Aetna use the information that it gets regarding prevailing fees?

A. Under our major medical contracts and today, under our basic contracts where they will say they will pay the prevailing fee under surgery, we must determine what that prevailing fee is. So it is our responsibility to establish what most doctors are charging for a certain procedure. This is the amount which is allowable both under our basic and/or major medical contracts.

Q. Does Aetna try to pay less than the prevailing rate in a locality?

A. No, we do not.

Q. Did Aetna's claims handling decisions on prevailing rates charged by doctors for particular procedures in 1972, result in a lot of disputes with employees about the amounts that Aetna was paying?

A. No.

Q. Are you aware of any statistics as to any lawsuits that were filed in connection with Aetna's decisions regarding prevailing rates for surgical procedures?

A. Yes. I do.

The COURT: Defendant, do you wish to look at the notes the witness is bringing out?

THE WITNESS: I have some notes, here.

MR. JOHNSON: No, Your Honor.

[94] THE COURT: All right. Very good.

THE WITNESS: From the period of September 1st, 1971, through December 30th, 1982, we had a total of 229 lawsuits, with respect to prevailing fees alone.

THE COURT: Would you repeat that, please?

THE WITNESS: Okay. From September 1st, 1971 through December 30th, 1982, the lawsuits that the Aetna participated in were 229. Now, it's not known as to when most of those claims would have been, I don't know if it is across the board. I would presume that the majority of those claims would have been early on in 1972 and '73.

THE COURT: 229 out of a possible—if everybody protested, what would the number be?

THE WITNESS: 229 out of the total claims that we paid in 1982, alone, were 33 million.

THE COURT: 33 million.

By Ms. McNown:

Q. So the 229 is for almost a decade and in 1982, you paid 33 million claims?

A. 33 million claims.

Q. Just in that year alone?

A. That's right.

Q. So in a decade of doing medical benefit claims, Aetna processed—what? Hundreds of millions of claims?

A. In 1979 we were doing 16 million, so I think we are [95] talking at lease 15 million claims a year, for the duration.

Q. As a result of Aetna's use of these computer collected, prevailing rates, did Aetna experience any higher incidence of cases going to a medical peer review com-

mittees regarding the determination of what the prevailing rate was?

A. Well, we had more notoriety about it. There were not that many more claims that were reviewed by peer review. There was an education process going on in 1972, because we were required by our contract holders to help in the controlling of the costs and also to be able to be more definite as to what the prevailing fees were.

THE COURT: So, in Aetna's basic plan, is it your testimony that there is not a certain sum, such as we pay $300 for appendectomies, period, That's not—

THE WITNESS: Your Honor, back in 1972, it was that way. We paid a certain amount because it was in the brochure that this is what we pay. But the current procedures and the current plans that are available, are called, Relative Value Plans, and we pay the prevailing fee even under the basic plans.

THE COURT: When was that change made?

THE WITNESS: I'm unaware of that.

THE COURT: Okay.

THE WITNESS: But these are the more commonly sold plans.

[96] THE COURT: All right.

By Ms. McNown:

Q. Back in 1972, did the major medical plan have in it, the concept that you paid the prevailing fee for doctors and surgical procedures?

A. Yes, we did.

Q. Okay. So that concept applied to major medical plans in 1972, but not basic medical plans?

A. That is correct.

Q. The basic medical plan had its dollar schedule of benefits for procedures?

A. Correct.

Q. You also mentioned that claims would involve supervisory review if a claim came in that had a longer hospital stay listed on the bill than what the processor would expect to see. How does the processor know how long a hospital visit for an appendectomy should take?

A. We have guidelines prepared by our home office medical department on the most common admissions, and these guidelines are at the processor level. It is a screen that they use and if it exceeded that screen, that was their trigger to refer this for further review.

Q. And if a processor saw that a particular claim involved more days than what the Aetna standard indicated, what would happen to that claim?

[97] A. The claim would be reviewed for the—in order to, again, develop additional documentation so that we can make a claim determination.

Q. If you got additional documentation that indicated additional procedures had occurred during that hospital stay, what would you do?

A. Or an underlying condition, or extenuating circumstances, that was all taken into consideration, and we would have honored the additional part. We were trying to pay that claim in full, but our guidelines would only let us accept whatever the going rate was. So, our job was to develop more documentation which would allow us to pay a better benefit.

Q. If If a claim came in which involved a new procedure, what would happen to it?

A. Generally, those are immediately forwarded to the home office, because no one in the field office is aware of what it is. At the home office level, our medical department has the facility of dealing with the national level of the various medical facilities—specialties, I should say—as well as the American Hospital Association, and having that specialty report back to us as to is this experimental,

or is this now acceptable treatment?

Q. And in responding to new medical procedures, is Aetna trying to follow what the medical community accepts as [98] established procedures?

A. That is correct.

Q. Does Aetna home office, as procedures become established, notify the regional offices?

A. Absolutely. It is imperative that we do that because it will cut down on the delay that each of the other offices might have in the development of the same information, and also gets the work off of my desk.

Q. So, once Aetna finds that a procedure A has become medically accepted, it will notify the claims offices?

A. Right. And we do this either through instructions such as information letters, or if it is a matter of surgery, of updating our manuals to reflect that procedure and information.

Q. Once the claims office is notified that new procedure A, is now an accepted procedure, would they continue to send that into the home office?

A. No, once the procedure is established, then that becomes a matter of course for the rest of the business.

Q. How many people are in the home office working on consultation on medical benefit claims, versus people in the regional offices?

A. Our regional, or field offices, have about 3,000 people and the majority of them are processors. In the home office we have 18 claim reviewers, or examiners as we refer [99] to them, and they have administrators, so I would think about 20 people, tops. And we funnel those claims from the home office to the various home office departments in order to gain the expertise or position on whatever the problem might be.

Q. So your 18 to 20 people who are claim consultants, handle the consulting work generally for all of Aetna's medical benefits business?

A. That is correct.

Q. If a claim comes in without complete information what happens to it?

A. If we receive a claim and the necessary evidence is missing, for instance, if we receive a bill from a surgeon that says $350 with no description of the procedure, we would have to document the file as to what actually went on. In that particular instance, we would pick up the phone and call the doctor's office and say "What was the procedure? You forgot to include it." If it was a hospital bill where the assignment was received and the total bill was presented but not an itemized statement included, that would have been a clerical error. We would ask for an itemized bill and that would be a telephone call. If it is a procedure with a doctor where his charges are exorbitant, according to our rules and guidelines, we would write him a letter and say, "Were there any extenuating circumstances? If not, could you [100] supply us with a copy of the report so that we could determine our benefit."

Q. When Aetna investigates claims, is it involved in the activities that you've just described?

A. Yes.

Q. Is that typically the extent of your activities in investigating a claim?

A. Extent of the activities, means is it limited to that?

Q. No, is that typically what you do?

A. It is typically, yes, very typical. Right.

Q. Are all claims paid only at one time, or can there be partial payments?

A. There are partial payments. We pay the benefits

that are certain and definite, and if there is a question, or if, for instance again, if the hospital bill—if we knew that the ten day stay was reasonable, and expected, and we see 20 days, we would honor the ten day stay and advise the employee that there's nothing he has to do, but we are asking the hospital for additional records to make a determination with regards to the balance of the claim. The same would hold true with the surgeon. If we allowed a certain amount for the surgeon's charges as to what we would accept, the balance, we would still tell the employee we are checking into the balance.

[101] Q. If Aetna is attempting to obtain more information to process a claim, does it deny the claim while it is waiting for that information?

A. No, we can never deny a claim until we are certain of our position. To do so would put the Aetna and the employee and General Dynamics in an embarrassment, once the additional evidence came to light. It is our job to develop that claim on behalf of the employee and General Dynamics, so that the justified payment is made the first time that we make it.

Q. When does Aetna take action which constitutes denial of a claim?

A. When all the facts are in, and we see that the benefits are paid in accordance with the plan. For instance, in what was disclosed here earlier, the case of the Workmen's Compensation claim, the processor would have caught that up front, to say this claim was submitted to us in error. It should be under the Workmen's Compensation Plan, or the plan was in effect on a certain date, but all the charges were incurred prior to that, that would have been caught up front and we would have denied it. And in our denial we quote the—or refer the employee to the brochure, or the certificate of insurance, that will allow them to understand how we handled the claim in that way, rather than a benefit that he might otherwise have anticipated.

[102] Q. All right. But prior to obtaining information which gives you a concrete basis for denying a claim, you do not take action to deny the claim?

A. No, we do not take any action, that's correct. We take the position of now we have the claim and now we must develop additional information. We put the claim employee on notice the fact that we received it but we haven't done anything with it, yet, as far as the benefit. We need additional evidence and we're arranging for that. Now, sometimes we may ask the employee for it, which we'll write them a letter and say, we need this or that from you and what happened.

Q. What philosophy does Aetna have in administering medical plans?

A. To pay everything that we owe.

Q. Once the facts are already known on a claim, if it is not clear whether an item is covered or not, what does the Aetna do?

A. Well, those claims are called the "gray area" claims. If we cannot make a determination to prove that it should be denied, those are ruled in the employees favor and we extend the benefits to them.

Q. So you pay the claim?

A. We pay the claim.

Q. The processing procedure that you're discussing [103] obviously takes some time. If you had a processor in the hospital waiting room or in the accounting section of the hospital, so that when the employee left the hospital, after a stay for surgery and was given his bill. He provided it to the processor at the hospital. Would the processor be able to determine how much was due on that claim on that day?

A. Yes.

Q. Why is that?

A. Because number one, we would have identified that this was a covered member of the particular plan, and

under the particular plan, we would have the evidence to us as to what benefits were available, and on a schedule basis there would be no problem in identifying the benefits available at that time.

Q. If the bill appeared to the processor to be higher than anticipated for the procedure which was performed at the hospital, could the processor obtain input from other Aetna consultant people by telephone, and make a determination about whether additional expenses were due or not?

A. Yes.

Q. And that could be done on that day?

A. Yes. The best resource on that day would be the doctors themselves, because they would be right handy to find out what was going on.

Q. So you could ask them if additional procedures had [104] been performed and could justify higher fees?

A. Right. Was this his customary fee? Were there extenuating circumstances, like getting him out of bed at 3 o'clock in the morning to have a tonsillectomy.

Q. You have reviewed the General Dynamics medical benefits plans, have you not?

A. Yes, I have.

Q. The General Dynamics plans have a provision for coordinate benefits, don't they?

A. Yes, they do.

Q. What is coordination of benefits, and how does it work?

A. Coordination of benefits is a feature that allows us to consider benefits that might be available under another plan. The most common case of coordination is where the husband and wife both work and both have a group plan.

THE COURT: Isn't that against the—violative of the rules of—I know you're not supposed to do it. Is that violative of a rule in the Aetna plan or any other Blue Cross/Blue Shield plan?

THE WITNESS: Your Honor, that they can have both insurances?

THE COURT: Yes. I know with the Federal employees, we're not allowed to do it.

THE WITNESS: That's right. That's right. You [105] cannot have dual enrollment.

THE COURT: So, anybody else can, is that what—

THE WITNESS: No, no. In this instance I was suggesting that the employee might be working for General Dynamics but the wife works for someone across the street, another plant.

THE COURT: Oh, I see, two non-Federal employee spouses?

THE WITNESS: That is correct. Right.

THE COURT: I see. All right. Proceed.

By Ms. McNown:

Q. Okay. You were describing to us, coordination of benefits and how it works.

A. Well, first for instance, if someone has had the Federal plan and also had General Dynamics plan, in the absence of—

Q. Let's not do a Federal plan.

A. But they had more than one plan. In the absence of coordination, both plans would pay the normal benefits, and the family would have made a profit on being ill. So, as a result of a response that the insurance industry had with the National Association of Insurance Commissioners, back in the '60's, they developed an order of benefit determination and coordination of benefit provision in all of our contracts. They provisions allowed the plans to cooperate, exchange [106] monies, and they exchange information, so that when both plans made their payment, 100% of the allowable expenses would be paid. But by order of benefit determination, the industry had accepted general guidelines under which they would operate. Let's for instance take—

Q. Is the net result that the employee receives 100% of his covered benefits, but doesn't make anything extra?

A. That is correct.

Q. And this is done by determining who pays first, in what order?

A. That is correct. And in the example of the husband and wife, if the claim was incurred by the wife, the wife's carrier would pay first. The same is true for the male employee. His claims would be paid by his plan first. In the case of a child, the fathers claim would pay first; the mothers would be picking up the balance.

Q. That child—you said the fathers claim, do you mean the fathers plan?

A. The father has incurred the expenses on his own behalf, his claim would be paid under his plan first.

Q. Right. The child?

A. The child—if we are talking about children, those claims are normally paid under the fathers claim—or under the father's insurance first, with the mother's plan picking up the balance. There is another instance, though, [107] where one individual may be retired and have a new employer, and have more than one group plan, and in that instance, whatever plan was the earliest plan, is the primary one.

Q. Under the General Dynamics medical plan, if the wife of an employee receives medical services in June, and she is not employed at that time, and later, say in August, she becomes employed and covered by a group medical plan, does coordination of benefits apply to her June claim?

A. No.

Q. Why not?

A. No, because in June there was only one coverage and the coverage that was available then, when the claim was incurred, would be liable to pay that claim.

Q. Doesn't coordination of benefits result in a lot of difficulties in application?

A. No. Up front, as soon as that other plan is known, the insurance companies cooperate among themselves, and determines who goes first and who goes second, and the employee becomes aware of this and they follow the order of benefits. So the first carrier pays its benefit, a copy of that explanation of benefit payment form, goes to the employee. He takes it and sends a copy of the bill on to the secondary carrier and they know exactly what to do. If the employee takes the option of sending both carriers the bill, simultaneously, the carriers get together and determine how [108] we are going to pay it.

Q. And are all the carriers following the same rules?

A. That is correct. They are.

Q. How do you know when processing a claim that there is more than one plan?

A. The claim form itself is designed to beg the question from the employee, are there more than one plans or employers in the family. Now, the first question is, is there anyone else in your family that is employed? The next question is, is there any other insurance? This allows the processors to take this information into consideration. If that fails, we still have the hospital and doctors, their bills and their forms, to give us the same information as to whether there is two or more plans involved.

Q. If, when the employee gets out of the hospital and renders his bill immediately and the processors in the hospital waiting room are waiting to do the processing, can she also on that day determine the benefits of coordination or benefits involved?

A. That is right, especially if we are primary.

Q. If you are primary. . . .

A. We pay our routine benefit.

Q. And if you are secondary?

A. We pay a benefit which when added to the primary's benefit, gives them 100%. And the day that we are at the [109] hospital, we would have to have the other

plans processor there, too, to tell us what they were going to pay as a primary carrier.

Q. If the two processors were there you could work out the full benefit payment for that employees stay in the hospital?

A. Absolutely. Yes.

Q. The General Dynamics plans provide limits for coverage for pre-existing conditions, do they not?

A. That is correct, they do.

Q. How do the processors handle this exclusion from the plan?

A. The processors are given instructions that, to compare the effective date of coverage for any new claim, if the effective date of coverage is recent, or if the effective date of coverage is showing a current condition that may be judged chronic, like gall bladder, they would look to see if during the three months preceding the effective date of that coverage, if there was any bills submitted or any charges made by a doctor or a hospital, or a provider of care, for that condition, and if so, the benefits would be denied. Now, these would be denied on the pre-existing condition, which sort of dovetails with the fact that if they have just joined our plan, and through our denial, if they were coming to us from another plan, the other carrier would be paying [110] those benefits, if there was total disability for that on-condition for upwards of a year.

THE COURT: What if there was no prior carrier?

THE WITNESS: Then there would be no coverage for that at all, Your Honor, under any plan.

By Ms. McNown:

Q. If it is found from the claim file, and any additional information that is received on the claim that there was no charge for that condition within this ninety day period, what happens?

A. Even if it is a chronic condition, that claim is honored and regular benefits apply.

THE COURT: Would you give an example?

THE WITNESS: For an example, I think gall bladder, because that is a chronic thing that plagues those people who have it. We would expect by the diagnosis itself, to say if they were covered the first of July of this year, and we see expenses incurred in July and August, there is a high suspicion that that is an ongoing claim, or an ongoing condition, but we would contact the doctor, or if it is a hospital bill, contact the hospital, to verify whether there was any confinement or treatment during that ninety day preceding effective date of the coverage. And if it wasn't, even though they might have had this condition most of their life, if they were going through that period without the [111] treatment, they would have the coverage under the General Dynamics plan.

THE COURT: What if he was treated by an osteopath?

THE WITNESS: Anyone, Your Honor.

THE COURT: Or a chiropractor?

THE WITNESS: Yes, for that condition. It would have to be for that condition.

THE COURT: Yes. How would you find out if he was treated by a chiropractor?

THE WITNESS: We would ask him. In other words, the bill we are looking at, would be generally the family physician, the one that would have been treating him right along, and the bill itself is tattletale as to whether or not, did you see him in 1978 and then 1983, on his ongoing claims. But it is based upon the evidence that we have at the time. Any and all doctors associated with that first submission, we would have to check back to see if there was a pre-existing condition.

THE COURT: All right.

By Ms. McNown:

Q. Now a pre-existing condition only applies to a new employee, is that correct?

A. That's correct.

Q. So, for most of the work force, it is not a problem?

[112] A. That is correct.

Q. Does the administration of the pre-existing condition exclusion of the plan, lead to disputes with the employees?

A. No.

Q. Why not?

A. Well, while an employee might be disappointed, we refer—when we have identified that this indeed was a pre-existing condition, and treatment was rendered during that period, before the effective date of the coverage—we denied the benefits and quote to them the reason why we are, and that references to their certificate or their brochure, as to why we have applied it.

Q. And to deny benefits, you would have to have found a charge within the ninety days?

A. That is correct—treatment.

Q. Do the General Dynamics plans have a time limit for filing of claims?

A. The brochure and the contract typify a period of ninety days under the basic, by which claim must be submitted, and under the major medical within one year from the date the expense is incurred.

Q. Do employees usually submit claims within the ninety day period?

A. Yes, they do, because those are first dollar [113] benefits that are available. There is no deductible or employee share needed, so they are quick to submit the claim for benefits.

Q. Because they get reimbursed?

A. Right away.

Q. What happens if a claim is filed beyond the ninety day period?

A. If the claim is filed beyond the ninety day period, that claim is handled routinely upwards of two years from

the time that it is incurred. In other words, the documentation that we have in those employee handouts, is to encourage early submission of claims, so that we have the resolved claims up front. It also helps us in the claim department because we only maintain those employee folders—those family folders, for upwards of two years, otherwise, it becomes a clerical problem.

In addition to that, we notice that most of the major medical claims come to us as soon as the deductible is over and usually that is at the beginning of the year, when people sit down to figure out their income taxes. That's when they first realize that they have a major medical benefit available. So, if the claim comes in, usually at the end of that time—but upwards of two years. We have evidence available to us that we have not paid that claim before, and we routinely accept those claims. That provision [114] is in the contract to protect the plan from any unjust claims, where we would be frustrated as far as our attempts to evaluate or to investigate it. If claims are submitted beyond that period, we would still go further and ask for an explanation as to why they were submitted to us. And, in the case of estates, or something like that, these are justifiable reasons and we might even have to go back and dig out some old files to prove that we hadn't paid it before. But, we give credit, or waiving our right to deny our claims even at that point.

Q. So you don't check into why there was a delay in processing the claim unless it is submitted—I mean, filing the claim unless it's submitted for processing more than two years after the incurral of the expenses?

A. That's correct.

Q. And, even if it is submitted after two years, you will process and pay benefits if you can?

A. If we can, right. We would have to develop additional evidence there to show why we still continued to pay the benefit.

Q. What number of claims are filed more than two years after the incurral of the expenses?

A. That's real rare. Predominantly, the ones that are forgotten, or put in a shoebox by the employees, or in the case of an employee death where the wife finally finds [115] someone to help her out.

Q. What percentage of claims, in your experience, come in within twelve months?

A. The majority of major medical claims are submitted within twelve months. The majority of the basic plan benefits—those first dollar benefits—are submitted within ninety days.

Q. By "majority" are you just saying 50%, or something higher?

A. Most. Most. I would say close to 85-95%, because the hospitals today are demanding that money as quickly as they can. We have even been asked to pay for on-going hospitalization where the patient is yet to be discharged from the hospital, and the hospital will send us interim billings and we pay them as they are received even though the patient has yet to be discharged.

Q. Under Aetna's insured benefits coverage—We have gone through testimony regarding the processing for medical benefit claims. Are the processing procedures which you have described this afternoon, procedures which would cover the processing of General Dynamics medical benefit claims in the 1972-'73 period?

A. Yes, they would.

Q. Have over the '70's, over those ten years, have there been changes in the way claims are processed under [116] medical benefit coverages?

A. No. They are substantially the same.

Q. Under Aetna's insured medical benefit coverage, when does Aetna's liability attach?

A. The contract has a definition of "date of incurred". A claim is incurred on the day on which the services rendered, or the supply is purchased.

Q. And that is when Aetna's liability attaches?

A. That is correct. That is right.

Q. If an employee receives services prior to the day he is employed by General Dynamics, and he submits the claim for those services after he becomes employed by General Dynamics, what happens to that claim?

A. Well, that claim is denied because the expense was incurred prior to the effective date of his coverage under the plan.

Q. If services are rendered when an employee is employed and covered by the plan, and then his coverage under the plan terminates, for instance, he quits and goes to work for somebody else, and after leaving General Dynamics, he files his claim for those earlier medical services, what happens to that claim?

A. Those claims would be honored because they were incurred while he was insured under our plan, or while he had the plan benefits as a covered member.

[117] Q. And the incurral is the result of the service being rendered?

A. Rendered during that period of time he was covered.

Q. And if a medical service is rendered to a dependent who is covered by a General Dynamics plan, and the dependent then loses his coverage under the plan, and the claim for those benefits is submitted after that, what happens to that claim?

A. For those expenses that are incurred during that period of time in which that person was a family member, they are honored under the plan.

Q. If General Dynamics terminates its medical benefit plan, what happens to claims for services which were received by the employees prior to the termination of the plan?

A. Those benefits have to be honored. That period of time, you are talking about run-off claims. We are liable to honor those claims as if the coverage was continuing.

Q. Because?

A. Because the plan was continued at that time the expense was incurred by a covered member.

Q. Does the handling of medical benefit claims result in disputes with covered employees?

A. No.

Q. Why aren't there disputes with covered employees?

A. When we deny a claim, we must be very specific as to what reason, or what exclusion generally, we are using. [118] We indicate on our explanation of benefit payment form, the reason directly to the employee, and it references the instructions, exclusions, definitions, limitations, that are described in the brochure that he received from the policy holder.

Q. What is the incidence of lawsuits regarding medical benefit claims?

A. Very rare.

THE WITNESS: Your Honor, I have additional factors here, if you would like.

THE COURT: What was 229 out of 33 million? What was that? Wasn't that the same question?

THE WITNESS: That was particularly on prevailing fee suits—prevailing fees.

THE COURT: And opposed to—what is this?

MS. McNOWN: Suits, in general, about medical benefit claims.

THE WITNESS: Other than prevailing.

THE COURT: For example?

THE WITNESS: For example, that we denied a claim because it was a cosmetic procedure. And cosmetic procedures are excluded across the board for the plan. And, yet, let's take for instance—a very—the case I'm going, where a child was born without a left ear, and because he was entering school, because of psychological reasons the father wanted [119] coverage, and asked us to pay bene-

fits. Now, I would want my child to have a plastic ear so he would not be ridiculed. So in that particular case, there was no accident, and there was no functional improvement. It was cosmetic, and specifically excluded under the plan. Now this is a very obvious case where you have a contract on one hand, and sympathy on the other. But this is a typical type of claim that the Aetna would have to be involved in, in defending our position and its contract.

THE COURT: Okay. And the 229 cases you talked about were?

THE WITNESS: Only on prevailing fees.

THE COURT: Okay. On the amount paid?

THE WITNESS: Yes, that is correct. On surgery, there was always surgery to it.

THE COURT: Okay.

THE WITNESS: These other cases are cases like the cosmetic surgery. In 1979, we had 16,000,000 drafts. Sixteen million claims, and 129 lawsuits.

By Ms. McNown:

Q. And this was for a medical benefit claims?

A. That is for everything, medical, disability, health and dental. And in 1982 we had 33,000,000, and we had 199. In those years—

Q. Okay. You said 33 million what?

[120] A. 33,000,000 claims were paid in 1982.

Q. And how many . . .

A. 199 lawsuits.

MS. McNOWN: May I have one minute, Your Honor?

THE COURT: Yes.

MS. McNOWN: That's all I have on direct examination, Your Honor.

THE COURT: All right. We'll take a ten minute recess and then we'll start with the cross. We now stand at recess for ten minutes.

(Whereupon, a short recess was taken.)

THE COURT: (Back on the record.) You may be seated. Defendant may start with its cross examination.

MR. JOHNSON: Thank you, Your Honor.

CROSS EXAMINATION

By Mr. Johnson:

Q. Would you have any instances where a worker would file a form seeking reimbursement, and as a result of his filing a form, be reimbursed less than what he sought on his form?

A. Yes.

Q. Why would that happen?

A. There are many instances; for instance, I personally believe that every employee in the United States firmly believes that its play will pay 100% of any expense he is going [121] to receive. Our job is to receive those bills and to process it in accordance with the precepts of the plan, the basic and the major medical; and explain—and by showing the payment, exactly how we handled it. And that probably, in more time than not, is the first time that an employee really becomes aware of what is available under his plan. So, for instance, if that employee expected full reimbursement for some surgery back then, and yet we had a scheduled benefit, we would be showing him that we would be paying less than what he had anticipated.

If he were unaware that we were paying on an incurred claim, and he incurred it prior to the effective date of coverage, he may be surprised to learn that the coverage is only effected for expenses incurred on and after the effective date of the plan.

If it was workmen's compensation, our job would be to politely say that nothing is available here, but it's available under another plan which is diametrically opposed to group insurance. In other words, if it's workmen's compensation, it's not group. And if it is group, it's not workmen's compensation. It is either/or.

So all of this is part of the routine screening process that the processor has to account for, and in line with the ex-

clusions that are right in the plan, if the doctors charge was the highest fee in St. Louis, we would have to tell [122] the employee what we are paying under basic, what we accepted under major medical as a prevailing fee, and the balance is just not covered by the plan.

So, in each one of those instances he would be using our explanation of benefit payment form, as news that is different than he anticipated.

Q. Was that rare that the worker would receive less than they sought in their form?

A. That would be difficult to determine. I don't know what you would use. For instance, if you'd use as a guide, how many times did the claim office receive a telephone call, then I would say that 25% of the time you would have a telephone call to our office saying "How come you only paid $400, where the doctor charged $500?" And, again, what that is, is a reiteration of our explanation in the first place. And sometimes the brochure or the plan description that was given to them when they were first employed, might have been lost or misplaced, and we would direct them saying, "Well, don't you have a copy of the brochure? Do you see that this is all that we can allow?" And, if they didn't, we'd ask them to go back to personnel and get a copy. Because all we were doing is handling their claims for them. we were computing it and we were doing it in their favor, as an agent for General Dynamics.

THE COURT: Defendant, would you speak up, please? [123] The Court is having a little trouble hearing your questions.

MR. JOHNSON: Yes, all right.

By Mr. Johnson:

Q. Would you have instances where the worker filed a form seeking reimbursement and received zero?

A. Yes, again, if they misinterpreted what was available. The quickest thing that comes to my mind is workmen's compensation. If they sent that to the group plan

for reimbursement, we would be returning it to them, saying, "Look, you just mailed this to the wrong place. It goes to the workmen's compensation area." It's a rare—

Q. Where else might that happen?

A. Pardon?

Q. Where else might that happen?

A. It's a rare instance, because really it's just a misdirected piece of mail. The effective date of coverage being subsequent to the date that a claim occurred, is more frequent than a workmen's compensation denial. But, then, again, you're only talking about the new employees that a company might have. But, if you compared all of the claims that we received, to those claims we paid zero, you wouldn't have a percentage, it would be really the exception.

Q. Once you had a worker who received medical treatment, when would you know whether what he had received was allowable under the plans?

[124] A. Okay. As we looked at the claim, we would be able to make a determination because of the description of the plan that was given to our processors, and our understanding of the contract, we would make a determination at that point.

Q. Then you would need to have a filed form and have some information along with that form?

A. Well, we need the information. Now, theoretically you could have gotten it at the time of the accident, if we were a witness, but the majority of the time, we're getting it with the daily mail. He's reporting to us "I've got these bills. Please process them for me."

A. And so he sends that in with his form?

A. That's correct.

Q. What would happen if the worker filed no form?

A. If he filed no form—now, remember in our description of how we processed claims—the form has got

to come from General Dynamics because it is on that form that we know that his man belongs to General Dynamics. Otherwise, it could be coming from anybody in the world and we wouldn't know which company or which plan to associate this with. But assuming that it is through General Dynamics, the claim is presented to us, and we are able to determine who he is, and what benefits are available at that time.

Q. And you are the ones who are mailing out reimbursements?

[125] A. That's correct. At the field office. And our claims offices would be paying the claims, yes.

Q. And the first word that you would have is when you receive the form?

A. That's right.

Q. You were mentioning earlier about what would happen if you had a—let's say you were at the hospital at the time the worker received his treatment. Would you make the worker file a form at that time?

A. I understood that to be by way of example. In today, at the Aetna, we actually are paying claims at the date of discharge because of a cooperative effort by computer, so that the information is entered by computer at the hospital. Now, are you saying—

Q. How about back in '72?

A. Back in '72 we would be first aware of a hospitalization, at the time of discharge, at the time that the hospital would have mailed the form, or the supporting claim form to us. Because, remember, before the hospitalization occurs, generally, General Dynamics would have completed a hospital form, guaranteeing to the hospital that this person is covered under the plan, and the hospital would allow them to gain admission to the hospital, in lieu of some other financial arrangement. So,

once that came to us, the coverage would have been certified already, and with [126] the itemized bill, we could make the determination.

Q. You mentioned earlier what would happen if you had the processor right at the hospital.

A. Yes.

Q. Would the processor look at the form, and the information with that form, at the hospital?

A. Correct. Yes.

Q. But the form and information was usually mailed in later?

A. That's correct.

Q. But that form and the information was—or, you had to look at that form and the information, and without that form, and without that information, you would not act on it?

A. We would not know that there was a claim.

MR. JOHNSON: That's all the questions I have.

THE COURT: All right. Redirect?

MS. McNOWN: Could I have one minute, Your Honor?

THE COURT: Yes.

REDIRECT EXAMINATION

By Ms. McNown:

Q. Mr. Loftus, when an employee submits his claim form for reimbursement for medical benefits, has he already, himself, calculated according to the terms of his plan, the benefits that are due and owing to him, and then provide [127] Aetna with that calcluation?

A. Well, why, of course, we don't require that. I would imagine that most people mailing a claim to us have some idea of what they would expect from us, because again, we have the brochure being available from the employer.

Q. But does the employee do the calculation in order to submit his claim to Aetna?

A. No.

Q. Aetna does the calculation for the employee?

A. Yes, on his behalf, that is correct.

Q. The employee submits all of his bills and information pertaining to a particular receipts of medical services, to Aetna. Is that correct?

A. That's correct.

Q. And Aetna uses all that material to make a calculation of the benefit for that employee?

A. Yes.

Q. When—

THE COURT: The Court will remind you, you are on direct, and you are using leading questions, and you should be not using leading questions at this time.

MS. McNOWN: Okay.

By Ms. McNown:

Q. Mr. Loftus, if a processor is at the hospital, would you tell us whether or not at that day, the facts that [128] are necessary to calculate the benefits are in existence?

A. They would be in existence.

MS. McNOWN: No further questions, Your Honor.

THE COURT: All right. Recross?

MR. JOHNSON: Thank you, Your Honor.

RECROSS EXAMINATION

By Mr. Johnson:

Q. Let me ask you about your last answer; you mentioned that the facts that you would need were there at the hospital, at the time the services were rendered?

A. Could be. Could be, and might be there.

Q. They might be there?

A. Yes.

Q. Would you need to actually look at those facts and to analyze them, before you would first make reimbursement?

A. Yes.

THE COURT: Is that it?

MR. JOHNSON: That's all I have, Your Honor. Thank you.

THE COURT: All right. If there are no further questions of this witness, this concludes the testimony of James Loftus. Thank you, very much, Mr. Loftus, for your testimony in this matter.

* * *

PLAINTIFF'S EXHIBIT 47,
DEPOSITION TESTIMONY OF C. ROBERT SCHALL

C. ROBERT SCHALL, called as a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

By Ms. McNown:

Q. Mr. Schaal, would you please state your name for the record?

A. C. Robert Schaal.

Q. What is your address?

A. 237 VanBuren Street, Lyndhurst, L-y-n-d-h-u-r-s-t, New Jersey 07071.

Q. Okay. By whom are you employed?

A. Prudential Insurance Company.

Q. When did you join Prudential?

A. In March of 1954.

Q. What is your current position with Prudential?

A. I am manager and senior claim consultant of the group health claim administration division.

Q. And what are the duties in your current position?

A. Prudential has in our eastern home office [5] approximately—they have nine claim divisions, mine being one of the nine. My division is unique inasmuch as the balance of the claim divisions process claims for our policyholders. In other words, they make the payment, they being Prudential, whereas my division is made up of clients who pay their own health claims. They have either a Prudential draft book or their own checkbook and they do their own processing, and my division supplies claim advice to these clients to be sue that they are paying in accordance with their policy provisions and with the current medical technology today that is known.

Q. How large is the staff in your division?

A. I have 30 people.

Q. How many clients or customers are assigned to your division?

A. I would have 90 clients in my division.

Q. Are these clients insured, uninsured, both, mixed?

A. There is a mix of everything.

Q. What specifically does your division do in working on the client cases that are assigned to it?

A. There is two major breakdowns, one being [6] supplying advice to these clients on referrals that the policyholder would be sending into us or clients would be sending into us. We provide them with authority guidelines of dollars amounts and types of claims that they can be processing. If something falls outsides the scope, they send it into us, or if they come against any problem that they are not aware of or know how to handle, it is referred to Prudential.

The other avenue is that we have people that would go out to these clients and conduct periodic claim surveys again to see that claims are paid in accordance with the

policy provisions. There is documentation of the billings to substantiate the amounts that are paid.

Q. When a new client comes to your division, does your staff get involved with any activities at that point?

A. When we receive what we term as underwriting briefs, which is the documentation of the plan from our underwriters, we then prepare instruction manuals. We then go out to the policyholder and instruct them on the level of benefits, how to handle the claims and offer our [7] services, as I say, as a consultant.

Q. Now, you referred to policyholder in that answer. Are you referring to just insured cases or to—

A. No. Policyholder, client, we use the term synonymous. I guess I should just refer to it as client.

Q. So when you make that reference, you are referring both to insured medical benefit plans and uninsured medical benefit plans?

A. That's right.

Q. Okay. What positions have you had previously with Prudential since you joined Prudential, and briefly what were your duties in those positions?

A. In 1960 I started in the claim division. I was a claim examiner going to an intensified training program, and, as I said, worked as a claim examiner processing claims. And then as we advance and get experienced you move into other levels of authority, of greater authority, and move to different titles of claim approver, assistant claim consultant, claim consultant, group claim manager, which is the field position, and then to my current [8] position as a manager and senior claim consultant. And each level, as I mentioned, has a different degree of authority, responsibility based on a person's experience.

Q. Okay. I believe you started explaining your duties in 1960. Did you positions with Prudential prior to 1960 involve medical claims processing?

A. It was basically a group insurance in the actuarial department working on dividend calculations and pension area items of that nature.

Q. Okay. So how long have you have been working in the health claim area?

A. Since 1960.

Q. 23 years?

A. 23 years.

Q. In your work in the health claim area have you observed and become familiar with how Prudential itself handles health claims?

A. Yes. I mentioned before in coming though the ranks, so to speak, from claim examiner doing field work with our clients and conducting the claim surveys, again, that I referred to before, so not only do you know what we do in-house, but what our [9] clients do in performing their claim functions.

Q. Okay. In observing the processing of health claims has that included observing the processing of insured health claims?

A. Yes.

Q. Has it included the processing of self-insured health claims?

A. Yes.

Q. Now, we referred to health care claims and medical benefifts. Would you tell us in general what is meant by health care medical benefits?

A. There is two groupings, categories that we can place them into; one being a basic coverage, that being a hospital, surgical, x-ray and lab, and there is other fringe benefits that are also classified as basic benefits, and then you get into the other major category and that being a major medical type expense.

Q. What is covered by major medical?

A. Major medical you would pick up any excess that would be considered eligible for many of the basic coverages that the base plan did not pay, and also items that are not covered under base plan, for example, drugs, office visits, any other routine [10] medical care. There are some supplies that would also be: wheelchairs, rental of equipment, purchase of durable equipment would also be covered under major medical.

(WHEREUPON, discussion was has off the record.)

By Ms. McNown:

Q. Okay. Have you had occasion to work on General Dynamics' and its affiliated corporation's health claims?

A. I first started working on the General Dynamics account in 1969 when I was assigned as the group claim manager that is conducting field surveys.

Q. And which facility or facilities did you work with at that time?

A. At that time I worked with the Electric Boat Division in Groton, Connecticut, in the Electro Dynamics Division in Effingham, and I also had exposure to, while not having direct responsibility for, claims surveys of the Quincy location, and then later when Quonset Pointe, Rhode Island location came aboard I serviced that account also.

Q. Would you describe what kind of work you have performed in connection with the General [11] Dynamics account in the health care benefit area?

A. Well, aside from conducting the claim surveys that I referenced before – in conducting a claim survey I guess I should mention that we work off of a health payment listing. This is a listing of payments that have cleared through our accounting system. We use this as the base to go on and conduct the survey to select the claim files and to review again the documentation, the bills to make sure

that they are in accordance with the policy provisions and the level of benefits that are paid is in accordance with the plan requirements.

Aside from that we—as the case requires it, we would be involved—I would be involved with claim training also.

Q. What do you mean by claim training?

A. If the facility had a loss of one of their claim examiners and they would hire a new person, they would be supplied with material to read, and then I would come on the scene and go over the detailed claim work with them as far as how to handle the processing of a claim. The local supervisor on site would then take up the person's development and review all of their claim work that [12] they would be doing, and periodically when I would go back to do another survey, I would concentrate then on that individual's claims that they had processed.

Q. Okay. How many times a year would you conduct a claims survey at a G.D. facility such as Electric Boat?

A. Electric Boat is done three times a year.

Q. And when you go out and conduct a survey, what period of time does each survey take?

A. Electric Boat takes four days. This would be a combination of all of the coverages of Electric Boat.

Q. Okay. When a survey was conducted at Electric Boat what quantity of files or claims would be involved in a claims survey review?

A. Again, basically it would be working off this health payment listing and pulling the claim files, looking at the various payments. There would be several hundred payments would be reviewed in detail to compare against this listing.

Q. Okay. Were there any other services that you performed on the General Dynamics' account in addition to claims surveys and assistance on [13] training personnel?

A. I was involved with the local medical society, attended several meetings, also visited local hospitals in the

area, worked with the plant physician at Electric Boat in the administration of the overall plan.

Q. You provide consulting work in all areas of the plan?

A. Yes. We prepare statistical reports also that would periodically be reviewed with the client as to the number of hospital claims, the physician involved, durations of various diagnoses, things of that nature.

Q. In 1969 was General Dynamics insured or self-insured for its employee health benefits?

A. They were insured.

Q. And it has been stipulated in the case that that change from insurance to self-insurance was in 1972.

Did you survey General Dynamics' claims while it was insured?

A. Yes.

Q. And for what period?

A. From 1969 to 1972, the date they turned [14] over.

Q. When they changed to self-insurance did you continue to survey medical claims at the Electric Boat facility?

A. I continued to conduct surveys from '72 through '75 when I was promoted to my current position.

Q. From your survey work at Electric Boat and other General Dynamics' facilities would you tell us whether or not you had an occasion to observe how the General Dynamics' personnel processed medical benefits claims?

A. Yes, by—you have to know from the time a claim was received through the particular handling of the claim to the drawing of the instrument and payment and how it is released, so I would know all aspects of the on-site handling of a claim.

Q. Would you describe the qualifications and training of the General Dynamics' personnel who processed medical benefit claims?

A. I believe that the people at Groton are extremely experienced and have a stable force up there and thus have quite an experienced force. So the amount of training on this particulary—for [15] this particular client has been minimal compared to other clients, so they have a very experienced staff.

Q. When General Dynamics changed from insurance to self-insurance for the health benefits, in what respect, if any, did the claims processing procedures for medical benefits change?

A. The only real noticeable change is in the payment of the instrument; the instrument being a General Dynamics checks rather than a Prudential draft. The physical payment would be the only—the claim handling woud remain the same.

Q. All right. I would like to now go through how a medical care benefit claim is processed, and I'd like to start in the period 1972 after General Dynamics changed to self-insurance. What happens first?

A. Well, upon receipt of a claim form and properly itemized bills, which could either be walked into the benefits area or mailed in—

Q. When you say, "Walked in," what do you mean?

A. The employee could walk into the area, just drop it off.

Q. Okay.

[16] A. Or it could be mailed in. It could be received from a hospital or another provider, but the claim would be received and clerical person would then conduct a review of eligibility by turning to the enrollment records. When the person was hired, they would enroll for the plan of benefits and they would check to see the employee's eligibility date and the—any names of dependent and dependent status on the enrollment record.

Q. Now, when you say, "Eligibility of the employee or dependent," what are you referring to?

A. That the employee has elected to participate in the General Dynamics' health benefit program.

Q. Okay. Once that check has been made, what happens next?

A. The claim then is turned over with the effective date shown on the claim form. It was turned over to a claim processor, and they would then put it with their work and they would handle claims in date order. And when that particular claim came up for processing, they would review the claim form in detail, which is very important step of the examining function, noting various questions [17] on the form both from the employee and also from the provider of the service on the reverse side of the form.

Q. Now, when you say, "Provider of the service," who are you referring to?

A. In most cases the provider would be a physician that would be rendering a service, whether it be surgery or medical care.

Q. Okay. Would a hospital be a provider?

A. A hospital is also a provider. Hospitals would be supplied with a hospital admission form, which is a certification again to the hospitals for a guarantee of payment that this individual is covered, and upon receipt the doors are opened to the hospital and they are allowed in. Upon discharge an itemized bill was usually attached to this form and then mailed to General Dynamics' location.

Q. Is what you just described on the certification to a hospital sort of a pre-clearance of coverage or benefits?

A. It is a standard procedure that has been adopted through the insurance industry with the hospitals that then they can—a person can get [18] in without putting money up front.

Q. Okay. Once—I think I interrupted you in your answer on the processing of the claim once it got to the processor.

A. After a thorough review of the claim form itself and any itemized bills that might be attached, they then turn to set up what we call a top sheet or a worksheet, terms are synonymous, which would display the type of surgery—excuse me, the type of service that is rendered. In other words, it would show the name of the hospital, the name of the physicians. Whatever bills would be attached to that claim form would be displayed in one column, as well as the dates that the service was rendered. The next column would show the appropriate charges that were incurred.

There are several other columns looking or visualizing it going across on a form that would—you would carry over these dollar amounts into the appropriate columns, depending upon they type of service and the level of benefit. For example, a hospital claim would be carried over to the hundred percent column and room and board and ancillary charges would be totaled up, and depending on the [19] amount of the plan, at that point would be shown in the hundred percent area. The excess would be brought over into the last column, which would be major medical column, which would be subject to a deductible and coinsurance, and each category is shown on this top sheet and you just segment each piece and handle each one.

You look at each bill knowing where each one would fall and just carry it across on the top sheet, and then you just summarize and total up your expenses and you can cross foot. This is also used—is mailed out with the payment so that the insured or the claimant would be able to see how their expenses were handled, each particular item. So it is an explanation of the benefits of how they were paid.

Q. Okay. So this sheet is sent to each claimant?

A. That's right, as well as a copy is kept in a claim file, which would allow us to conduct our claims surveys, also.

Q. You mentioned co-insurance when you were discussing major medical. What do you mean by co-insurance?

[20] A. Co-insurance would be applied to an expense, and, again, depending on the type of expense you have different co-insurance amounts, the most common being an 80/20 percent ratio. It could be 75/25, or for some specific type services such as psychiatric it could be a 50 percent co-insurance benefit.

Q. When you say 80 percent, 20 percent—

A. 80 percent would be paid by the plan and 20 percent by the claimant.

Q. So the plan pays part of those expenses and the employee pays part of those expenses?

A. Depending on the type of expenses, that's correct.

Q. Okay. What tools does the claim processor have in order to be able to make the calculation of basic medical benefits?

A. Well, as part of the material that we call tools of the trade that would be supplied to each one of our clients we provide them with a directory of hospital facilities so that they would check on the eligibility of the institution. We have supplied them with a surgical schedule or schedules, as the case might be, for the various plans in force [21] that would enumerate the procedure, procedure code, and the dollar amount of the surgical benefit for that particular code and procedure performed. This surgical schedule runs in the neighborhood of 70 plus pages. It is a very comprehensive schedule, and any procedure that might not be listed they are instructed to send into Prudential for advice.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Okay. You referred there to procedures. Are you referring to operations?

A. Yes, surgical procedures.

Q. Okay. Like an appendectomy or a tonsillectomy?

A. That's right. Tonsillectomy, delivery, paternity, obstetrical care.

Q. Okay. Are there any additional tools that the examiner or claim processor has in order to calculate the major medical benefits?

A. One item of particular importance that we supply them with is an eligible/ineligible guide which lists various durable equipment purchases and rental that they may see on a particular claim. It [22] lists, not only those that are acceptable, but those that are not acceptable. They either accept some or conditionally depending upon the condition involved for the person. There is a code on there to indicate whether it is acceptable across the board or just for a particular condition.

Q. Okay. Anything else that the examiners have as tools in order to calculate the benefits on a medical benefit claim?

A. Well, of course, they would have a description sheet outlining the level of benefits for that particular plan so they would know the dollar amount of benefit for a surgical procedure, for hospital room and board or semi-private room rate or whatever the plan might call for, what level under that particular code.

Each of the General Dynamics locations and plans have a—what we call a branch code, and that is identifiable to the plan of benefits both surgery and also the hospital. For example, some plans might call for $60 a day room and board, some might call for 65, some 70, and they keep, of course, over the course of time changing and increasing as negotiations develop.

[23] Q. So the processor has the current benefits provided by the plan?

A. That's correct.

Q. Once the calculations have been completed on a claim, what happens next to that claim?

A. Like I say, the total are all brought down and calculated and cross foot. We have some statistical coding that appears on the bottom to indicate the type of benefit, hospital, surgical for our reports that a health payment listing I mentioned before is produced off of and it goes to an area where the payment instrument would then be drawn and signed along with this work sheet, top sheet. They would be mailed out to the claimant or if benefits were assigned, a copy would go out, or that part of it would go out to the provider of service, the hospital, physician, if benefits were assigned, and the employee at all times gets a copy of the work sheet.

Q. Okay. So there are direct payments at times to the hospitals and doctors?

A. To accommodate the employee in assigning—if he assigns benefits.

Q. All right. The claims processing that we [24] have gone through sounds like a fairly simple claim. What happens to claims that are not that simple, that have some complicating or additional features?

A. Any plan that falls outside of the guideline that I mentioned before that is supplied to them or any question that they might have, it doesn't have to fall outside the guideline, is sent into my staff and it would be reviewed and a decision then would be made and sent back to the location giving them the direction on how to handle the claim.

Q. So Prudential provides consulting for certain claims that are referred to them by the General Dynamics' facility?

A. I think we can say those claims that fall outside of the routine processing.

Q. What percentage of claims get referred to Prudential?

A. Our normal book of business is—I guess the way I can explain this based on a division and staffing would represent between 90/95 percent of claims are handled routinely.

Q. Does that mean that Prudential does get referrals on those 90 to 95 or do not?

A. We would get referrals on the 5 to 10 [25] percent. I would also say though, as I had mentioned before, that due to General Dynamics' experienced staff that they have been fortunate in having over the years that their referral rate would even be reduced. I would say theirs would be closer to 95 percent. We would only be seeing 5 percent of the claims, if that even.

Q. Prudential would only be seeing 5 percent of the claims?

A. That's correct. Prudential would only see.

Q. Who at Prudential provides the consultation on these roughly 5 percent of claims that get referred into it for review?

A. Well, I have experienced staff in my division and the people that I have are—again, compared to the other divisions that I referred to before—are more experienced because we are actually receiving referrals from clients who have experienced staff out there, and our people would have to know how to handle the more difficult or involved claims, so these claims would be coming into experienced staff within my division. And also within the division we have level, again, of authority and involvement depending on the type and [26] the nature of the situation, and possibly would even come up to me for final resolution.

Q. Does your division have any support facilities from Prudential that are outside of your division or does your division do everything?

A. No. The division has several support areas, some are outside of our physical area, but one—we have a physician that is on-site. In fact, he is physically located in my division even that we would go to and either refer via a form with the claim documents or go and speak with him, sit down and discuss the particular situation at hand with him.

Or the other area would be our legal staff, which we would refer any legal questions to that might involve state laws or requirements, and we would send it to our law department, and, again, there are attorneys there that work on just our group book of business, and they would return it to us and we then would advise our clients. And in-house we also have, of course, our own underwriters that we would go to for any statistical information that might be necessary. Copies of the contract, things of this nature would all be there [27] so we could have that accessible to us.

Q. Okay. You stated that the staff in your division are experienced. Is there any general level of experience that those people have?

A. From a time standpoint?

Q. From a time standpoint.

A. Most of them would be, I'd say, between 10 and 15 years with us.

Q. Processing medical claims?

A. They would have prior experience in processing the claims, and that is how I pick my people from the other divisions. After the people have gained the experience in processing claims, then they come into my division, so that is why they are—have more seniority than what you will find in the other processing division.

Q. Okay. Do the General Dynamics' medical benefit plans have any items or categories of charges which are excluded from coverage?

A. Yes.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Do the General Dynamics' plans pay for [28] items which are not reasonably necessary for medical care of sickness or injury?

A. No. It is one of the excluded items in the policy.

Q. How does an examiner or a claim processor determine whether or not a charge is reasonably necessary for care of a sickness or injury?

A. The examiner would have, again, the parameters of the guidelines that we provide. They would gather the information pertinent to that particular item or service that was rendered, send the facts into us or call us. We try to expedite it first over the phone. In most cases, though, if it is getting into any kind of a technical nature, we will request that the file be sent into us, and then we would review the facts that are presented and again with other—our medical or law department is a type of question at hand, it would then be resolved.

Q. Okay. Does an examiner, say, at Electric Boat use any of the tools that have been provided to them to determine whether or not charges are reasonably necessary for specific types of care?

A. Yes. They would have again [29] eligible/ineligible guide, past experience. When we refer claims back that they might have, they could very well come across another plan that we were paralleling, a prior claim that was referred to us with all the facts, and then they would use that. They have their own library that they would set up and establish on referrals into us.

Q. Okay. Do the—

A. Experience is one of the big items here to know.

Q. Would the examiners at Electric Boat be able to determine that various charges were reasonably necessary for care without referring those questions on to Prudential?

A. They would definitely know if something fell out of the norm and that it should be referred into us. In the

training what we try to get across to everybody is that certain claims a bell will ring, and that is the time that you have to look forward to going further with the particular claim. Most of the claims, as I have indicated before, are routine claims. It is those claims, those exceptional claims that you will come across occasionally that will require some different type of handling and [30] maybe have not had the exposure, but we train them to identify those problems so that would trigger off this bell that I referred to and get it going into Prudential.

Q. When a claim is sent into Prudential for review on the issue of whether a charge is reasonably necessary for care, how does your staff person make a determination on that issue?

A. Usually we would have the background information from the provider of service citing the reason why he did render whatever services in question. It would then be reviewed by our laypeople, my staff, and they would consult with our in-house physicians to determine how the medical world reviews this particular item that is in question.

Q. If the medical world regards it as usually necessary, what happens?

A. It would filter back to our office and we would indicate on the referral that this item is acceptable and send it back to the location and they would process the claim.

Q. If it is determined that it is not generally accepted by the medical profession as a treatment, what happens to that kind of claim?

[31] A. We then provide the location again with the reasons so that they could incorporate it in a letter. Usually if we are knocking something out of any consequence we would have it done by a letter informing them of the reasons and the position of why it was not accepted, and also in the event there was someway that they could advise them to make the claim whole to what we would need for further review, if that was the case.

Q. When you say "Make the claim whole," what are you referring to?

A. If there should be some particular item that based on what we have submitted here in our decision and how the decision was arrived at is not, let's say, in the proper vein of what the provider meant it to be, how he expressed it or what the information that we have, it could be off on another tangent, he would then send it back and that would be making the claim whole or correcting the information. Any clarification of the details, in other words.

Q. You are talking about providing additional information?

A. Additional information, right. If any [32] additional information is available.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Okay. And if additional information on a claim is submitted, is that considered by the processor in arriving at a final resolution on the claim?

A. It would depend on the complexity of the problem at hand. If the processor felt that the information received was clear and allowed them to pay it, then they would just process the claim or they would get this additional information and pass it on to us. We could either at that point stop and say we are in agreement with it and have it—return it to the location, or we could go to our medical department and consult with them on it and they in turn, depending on what they come back with, it would be again back through the ranks again.

Q. But this additional information is considered by the processors?

A. Definitely. And every time a referral comes in or request for review of a referral or prior decision, it is always reviewed at a higher [33] level than the one previously.

Q. When charges come in at the field office do the examiners there use this list you referred to of eligible charges/ineligible charges to make determinations that—

A. Yes.

Q. (Continuing)—items are covered by the plan or not covered by the plan?

A. Yes.

Q. Does the General Dynamics' medical benefits plan cover charges for services or supplies which are excessive?

A. No.

Q. How does an examiner determine whether charges for services or supplies are excessive or not?

A. Services with reference to surgery, they are provided with a file which would show by geographical area the 90th percentile for a particular procedure in a geographical region. They would look up this profile that is made available to them to see and compare it against the fee that the provider has rendered to see whether it is less than or equal to the amount. If it is less than the [34] amount or equal to the amount, then the claim is processed. If it exceeds that amount, there is criteria that they would have as far as what information would then be requested, the most common being an operative report.

Q. Why would you be requesting information if it is higher than the 90th percentile?

A. Well, to see if there is any additional information. We are working with an itemized bill for a claim form which the physician or a secretary is completing it might have been very brief in giving a description of the surgery. However, if you get into the operative report there might have been adhesions or other complications, and that would then warrant additional dollar amount of benefits that might be considered and the fee may well be within the acceptable limit then.

(WHEREUPON, discusson was had off the record.)

By Ms. McNown:

Q. You referred to the processors having a surgical profile which shows the 90th percentile of surgical fees for

procedures. Would you explain what you mean by 90th percentile? I think it may be [35] clear to you, but not too clear to us.

A. Over the course of time and periodically updated we gather statistical data on various surgical procedures which are coded by the procedure and there is values applied to it and with the dollar amounts and you arrive at an amount that would be considered reasonable and customary, again, doing a mathematical formula of calculating a 90th percentile. It is a mathematical formula is what it is.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. When you say, "We collect information," who are you referring to?

A. Prudential computer system.

Q. Okay. Is it correct that when this mathematical formula is applied to the 90th percentile means that 90 percent of the fees for that procedure are—

A. In that given area would be acceptable.

Q. (Continuing)—are at or below that level?

A. That's correct. That's correct.

Q. Okay. So the 90th percentile approves 90 [36] percent of the fees in an area for a particular procedure?

A. At least 90 percent. It could be even a greater percentage depending on the array of charges.

Q. Okay.

A. And again it is a mathematical formula depending on the number of claims in it. You have to have ten or more claims in order to come up with the 90, but, again, depending on the array of charges it could be accepting more than that.

Q. Okay.

A. And this is used, not only by General Dynamics—or it is used by Prudential on all of our accounts and all of our clients that process their own claims.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Does the General Dynamics' medical benefit plan exclude in coverage preexisting conditions?

A. Yes, it has a preexisting exclusion.

Q. How does a claim processor determine whether or not there is a preexisting condition?

A. The initial review of the claim form would [37] be the first and really the only key to look at to see the type of illness or injury, to see the onset of the service, which is one of the questions on the reverse side of the claim form, and if it was an accident, the time and date of how soon prior to or around the effective date of the plan the condition commenced or the prior service was rendered.

In other words, if you looked at a condition, let's take a cancer situation, and somebody came to work two weeks ago for you. After the effective date—let's say you have a three-month waiting period, and then two months after that you would get a claim in and it showed as a diagnosis cancer. This would, of course, cause rise to suspect that when was—or at least raise inquiry as to when was the onset of this cancer. It could very well be within that three-month period, but assuming it was prior to the effective date this would be something you look at.

If it was an accident, on the other hand, somebody fell of a bicycle or while they were jogging they fell, then that would be something that would happen at that point in time and that would not be pursued at all.

[38] Q. Okay. If the condition for which the charge was rendered is of the type that could be preexisting, how does the claim processor know whether or not to exclude it from coverage or to include it for coverage?

A. If there is a possibility that it would be something that might have incurred within the 90-day period, they would in most cases write to the provider of the service and ask that request with a letter.

Q. The provider being?

A. Whoever rendered the service that we had the bill for.

Q. Such as a doctor, or hospital?

A. Doctor in most cases it would be.

Q. And—

A. Doctor with the question, "Did you render a service within such a period of time for this condition?" and the doctor would sign it yes or no; he would date it and we ask for what charge because you have to have a charge. That is the key word here is that there was a charge incurred for this condition.

Q. In what period of time?

[39] A. Within the 90-day period prior to the effective date of the claim.

Q. If there was no charge for the condition within that 90-day period—

A. You could not invoke the provision then.

Q. (Continuing)—you would have to pay the claim?

A. Pay the claim.

Q. If there was a charge within the 90-day period?

A. It would be deferred until there is a period of 90 expense-free days or six months, whichever comes first.

Q. And in processing the claim you rely on the provider's statement of whether there were or were not charges in this period?

A. Yes. That is the only real source of document that you would have to go on.

Q. What happens if a claim is submitted without complete or adequate documentation?

A. Depending on the information that we are talking about, if a person left off the date of birth or something like that, we could look at the last claim in the file to see, if it was Social [40] Security number or something like this, if the individual failed to—

Q. If it was that kind of information what happens?

A. We process the claim then.

Q. Okay.

A. If it was something that the person did not answer the questions as far as a Worker's Comp or coordination of benefits, then we would ask that question. We would go back to them. Again depending on – Dynamics, I think, is unique also. They have – the benefits department has a good rapport with all of their people. They pick up the phone and try to contact the person and chances are they would get that question over the phone. Coordination question again could be checked out on a prior claim form, although there is a possibility that it could change from two months ago when they submitted the last claim, but that would not be a key item at that point.

Q. Okay. If a claim has been submitted without –

(WHEREUPON, discussion was had off the record.)

[41] MS. McNOWN: Strike that.

By Ms. McNown:

Q. If the claimant does not submit the doctor's bill or itemized charges, what does the processor do with that claim?

A. That part of the claim that is not whole, let's call it – if it is a bill – let's say five bills come in, one bill does not have an itemized bill, is not itemized, then the balance of the claim in most cases, 99 percent of them, would be processed, and that one bill would be then – on the worksheet we would ask for completely itemized bill or whatever is missing. It might be the diagnosis, it could be the date of the service, it could be the type of treatment that was rendered. Sometimes we get bills in just say, "Balance due" and that does – that is not acceptable.

Q. So you ask the claimant for the additional information?

A. We would ask the claimant for that and upon receipt of that then the balance of the claim would be paid.

Q. Do the General Dynamics' medical plans have any provision for coordination of benefits?

[42] A. Yes.

Q. Would you briefly explain what coordination of benefits is?

A. Coordination of benefits comes into play when two or more covering individuals have group insurance plans to cover the medical expenses that have been presented. It could coordinate to the point that would allow the individual to collect 100 percent of the allowable expenses, but would not allow them to collect 100 percent under both plans.

Q. Okay. You referred to two people having group health coverage. Are these persons family members related to each other?

A. Yes. It could be the husband and wife or spouse. It could be dependent children that might have a group coverage.

Q. How is coordination of benefits accomplished? How does that work?

A. Again, the initial review comes from reviewing the claim form, and there are a series of questions about is your spouse employed, or if it is on a dependent child, is that child covered and, if so, where, name and address, and then there is a series of questions on other group coverage and the [43] type of coverage and who the carrier might be or the provider of the benefit and any policy or control number.

Q. Okay. If there is information on a claim form that says there is other group medical insurance or coverage available, what does the processor do with the claim?

A. Well, one of the first things they would do would be to look at a prior claim. This way they may have been through it already on a prior claim which would allow them to determine if the plan is primary or secondary.

Q. When you say, "The plan," you are referring to whose plan?

A. The General Dynamics' plan or the other plan, as the case might be. There could be prior handling of this and it would be part of the file, and it would remain then and that would then allow them to process the claim at hand. If we were primary, for example–

Q. If General Dynamics was primary, what happens to it in the processing?

A. The claim would then be just paid.

Q. And by "primary" you mean what?

[44] A. That the insurance industry has guidelines and rules that are established to determine primary and secondary roles of the carriers or the plans in question. We go through the process of determining who the patient is and how the plans fall to determine who was primary, who was secondary.

Q. If General Dynamics is primary, does that mean it pays first?

A. That's correct.

Q. If it is secondary, does that mean it pays second?

A. That's correct.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. If General Dynamics' plan is secondary, how the claim get processed?

A. Again, if there is a phone message of who they contacted on a prior claim or if there was nothing in a prior claim, let's assume, they would then based on the information on the form as to where the other employer is, it could be a local employer, more than likely is a local employer, they would pick up the phone and call the benefits person [45] at the other employer and obtain the information as to what type of plan they had, the details and provisions and so that they could determine then who is primary and who is secondary. If that is not possible, it could be a local employer, but it is handled by another carrier, another state, let's assume, or someplace else, the industry has an

inquiry form that goes between the carriers to solicit the information as to who is primary, secondary, the provisions within each of the plans, and they also itemize the bills and what liability would be responsible for each one under the situation. So there is an exchange of information by the two carriers that would allow them to take their positions as primary or secondary.

Q. All right. If General Dynamics is secondary, how does that claim get processed?

A. Well, once it would be determined as to what the other carrier or the other carrier or the other plan paid, then we would calculate our normal liability and subtract what the other plan paid and then determine the amount that would make them whole up to a hundred percent. We would not pay any more than our normal liability.

[46] Q. Okay. Now, who established, if anyone established, the rules determining who is primary and who is secondary when there is dual or multiple group medical insurance coverage?

A. This came out of the health insurance industry itself through the HIAA, which is the Health Insurance Association of America, which is sort of the focal point of information to the industry.

Q. So—

A. And it was made by the carriers as a group with them.

Q. Are there multiple sets of rules or is there one set of rules?

A. No. There is one set of rules. I would like to just clarify that. There was one set of rules in 1972. Today they are starting to go on different tangents with divorced people, with females with children. Normally the rule would be to follow the male, and with different types of review of this particular provision, they are starting to look in different areas, but that has not been accepted or approved by all of the insurance departments and, therefore, not in

place [47] in every instance. So there are differences today, but back then in '72 and up to just the last year or so it was one set of rules.

Q. Can you briefly describe what those rules were back in '72 as to the order in which plans paid benefits?

A. Basically if you covered the patient and the spouse or the other dependent had coordination of benefits you were prime. If you covered the patient and the other plan did not have a coordination provision in it, then they were prime. Any plan that did not have it in was always prime first.

Q. Any plan without a coordination of benefits provision was always primary?

A. That's correct. When your plan had a coordination in it.

Q. Okay. If both plans had a coordination of benefits provision in it, then how did they sort out who was first and who was second?

A. By looking at who the patient was. If it was your employee, then the plan which covered the employee would be prime.

Q. Okay.

[48] A. When you get down to children, it is the plan that covers the father, the husband as the employee would be prime.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. If General Dynamics is the primary plan under coordination of benefits, does the existence of coordination of benefits substantially lengthen the processing time?

A. No.

Q. If General Dynamics' plan is secondary under coordination of benefits, does that substantially lengthen the processing time?

A. Not substantially. Depending on the availability of the information. Like I said before, it could very well be in

the file and there would be no time lost at all. If it was a phone call, it would be handled that same day. Then if the industry form went out—the industry is aware of the importance of making this mechanism work and we as an industry all agree to then reply to these inquiry forms.

Q. In the General Dynamics' plan is there any [49] time limit established for filing claims?

A. No.

Q. In processing the claims are there any rules about late claims?

A. No.

Q. You have mentioned facilities at General Dynamics for which General Dynamics' personnel processed the claims. Are there any facilities of General Dynamics for which Prudential itself processes the claims?

A. Yes. One of the largest one is the corporate office in Clayton, Missouri, where we would process the claims in another claim division in my office.

Q. Are there some other facilities?

A. Yes. The Electro Dynamics Division, some, I think, Stromberg units, but that would be it.

Q. What differences, if any, are there in the way that claims are processed under the medical plans where Prudential does the processing rather than General Dynamics?

A. The processing would be the same and the payment instrument is the same also with General Dynamics.

[50] Q. Mr. Schaal, are medical benefit claims denied until they are paid?

A. No.

Q. Did the General Dynamics' medical benefit plans provide that employees would be paid 100 percent of all of their medical expenses?

A. No. It depends on the level of benefit for the particular coverage that the service was rendered under.

Q. Under the terms of the General Dynamics' plans are all amounts that are submitted with the claims forms paid?

A. No.

Q. Why not?

A. Because they would—could fall out of the covered policy provisions; they could be in excess of the amount of what would be considered reasonable and customary, or they could be not medically necessary for the care and treatment of an illness.

Q. Under major medical does the plan also provide a provision for the employee to pay a given percentage of their medical expenses?

A. Yes. There would be a 20 percent or a—[51] could be a 50 percent in a psychiatric situation, as well as they would have the deductible corridor to take care of.

Q. Do the General Dynamics' plans cover Workmen's Compensation items?

A. No. It is one of the exclusions.

Q. How does an examiner determine that an expense is or is not excluded under Workmen's Compensation?

A. Well, we would start back with the claim form again. There is a question on the form for the claimant to answer of whether or not the expenses arose out of or in the course of employment. There is a question for the provider of the service, the physician, same type of question as well as the employer from their records of whether there was any report of any accident or compensation, Worker's Comp claim filed.

Q. So the examiner looks at that information to see whether it was Workmen's Compensation or not?

A. That's correct, as well as there is another question on a claim form for all accidents; they must be explained as to the type of accident, how it occurred, date and time, and if it was in the [52] normal workday, let's say, and the time was during the work hours, this would be suspect then to raise a question over whether or not this arose out of employment. It could be the person had that day off or something else, but it would just be something that would trigger perhaps a call to verify that.

Q. So if there was a question as to whether or not a claim was covered under Workmen's Compensation, the processor would call for more information?

A. Would call for more information. Again, we have other areas such as the provider or the hospital, the physician that might indicate also whether or not person goes to the individual and says, "Hey, I fell on the job. I did this, I did that on the job," and that is how he would answer that question, as well as the employer's record, as well as what the employee is alleging when he is filing the claiming. So there is three areas plus the question as far as any accident on the form, so there is four areas and you put them all together and develop the picture.

Q. Does the handling of the medical benefit claims under General Dynamics' self-insured medical [53] plans result in disputes with employees?

A. I wouldn't call them disputes whenever there might be misunderstanding or clarification would be required as to why or how a particular benefit was paid or what part of it was paid. So most cases the level of benefits that is paid might be in question.

Q. And is that explained to the employee?

A. It would be explained, but again sometimes they may not just understand the reason for excluding an item on that work sheet that I referred to.

Q. Okay. If after explanations have been given to employees who make inquiry about their plan of benefits, in your experience what is the incidence of lawsuits relating to the General Dynamics' medical care benefit plans?

A. Very minimal. I can recall two suits involving this client going back to '72; one I had personal knowledge with up at Electric Boat, that is how I know that one, and then there was another one at Quincy, I believe, but that was it.

Q. In all of the years that you have been working on the General Dynamics account?

[54] A. That's correct. That's correct.

Q. From your experience with Prudential what is the incidence of lawsuits over medical benefit payments?

A. I think when I look at the ratio of the number of payments that we made in 1982, we had over 450 million payments, and I checked the records of suits in our eastern home office that I work out of and we had 96 suits in 1982 and at the end of the year 46 of them had been resolved. There were 49 remaining open.

Q. So for your eastern office, is that—

A. That's correct.

Q. You had 450 million claim payments?

A. Payments, that's correct.

Q. And 96 lawsuits?

A. 96 lawsuits.

Q. In 1982?

A. In 1982.

Q. And this relates strictly to medical benefit claims?

A. That is medical claims or clients.

Q. Under the terms of the General Dynamics' medical benefit plan if a person incurs medical [55] bills prior to being an employee of General Dynamics and the person then becomes an employee and covered by the plan, if he submits those earlier bills to General Dynamics for payment, what happens?

A. They would be denied because the expense was incurred prior to the effective date of the plan.

Q. Prior to the date of the empoyee is a covered member under the plan?

A. That's right. Prior to his date of eligibility.

Q. Under the General Dynamics' medical benefit plans if an employee is covered by a plan and receives medical services which are covered by the plan and then he quits and after quitting he submits a claim for those earlier medical services, what happens to that claim?

A. That would be paid. That would be processed.

Q. Why would it be paid?

A. Because the expense was incurred while he was a covered individual.

Q. Under the General Dynamics' medical benefits plan if an individual is a covered dependent under the plan and receives covered [56] medical services at that time and later the dependent loses his covered status, he graduates from school or something, if the claim for those earlier services is submitted after he lost his covered status, what happens to those claims?

A. The claim would be paid again because the expenses were incurred during the period of time that he was a covered individual.

(WHEREUPON, a recess was had.)

By Ms. McNown:

Q. Mr. Schaal, does Prudential or General Dynamics claims processors have any general philosophy about claims handling?

A. For years we have always advocated that every claim should be paid in accordance with the policy provisions of the contract. We pay every penny that is payable and anything that is not payable is denied. We have a term in the business that we call the gray area, and if that gray area cannot be clarified, then the claim or bill in question is rendered in favor of the claimant, is paid then.

Several years back we committed to writing a Prudential philosophy on claim handling which has [57] been given to our internal staff, as well as to our clients processing their own claims, and that is the copy that we have here in front of us. While that has been published in 1975, I believe its principles and practice has been in effect pretty much from day one.

MS. McNOWN: Okay. Perhaps we ought to mark it since the witness has referred to it in his answer.

Would the reporter mark this as Schaal Deposition Exhibit No. 1?

(WHEREUPON, said document was marked Schaal Deposition Exhibit No. 1, for identification, as of 9/7/83.)

(WHEREUPON, the document was tendered to the witness.)

By Ms. McNown:

Q. I show you Mr. Schaal a document which has been marked as Schaal Deposition Exhibit 1 and ask if you can identify that.

A. Yes. That is the referred document, Prudential claim philosophy.

(WHEREUPON, discussion was had off the record.)

[58] MS. McNOWN: That is all my questions on direct.

(WHEREUPON, there was a short interruption.)

[59] MR. JOHNSON: I just have a very few questions.

CROSS-EXAMINATION

By Mr. Johnson:

Q. First, you mentioned that the worker would either walk in or mail in the form.

What would happen if no form was sent in?

A. If just a bill would be received?

Q. Or no information at all.

A. Okay. The employee then would be contacted to have either a claim form completed – I should go back and state that the first thing that would be done would be to look in the employee's file to see the last time a claim was submitted, that we had a completed claim form.

If, for example, a week ago he had submitted a claim for hypertension and the attached doctor bills and some drug bills and if he got one bill and he comes along and drops off a bill at the counter in the benefits area, we would accept that bill with the data claim form. It would be processed.

If we looked back in the file and there was no prior file within usually six months, as a rule of thumb that we use, then we would ask for a [60] completed claim form because the status of coordination of benefits, the diagnoses or whatever it might be, might have changed in the interim period.

Q. What if the worker sent in no information at all, would you normally hear from the hospital or from the doctor, or were you relying on the receipt of the form?

A. If we received a bill directly from the hospital, which is usually the way the bills come in from the hospitals, comes directly into the benefits area, we would then contact the employee informing them that we do have a bill and request that we be—send a claim out to him either through intercompany or through the U.S. mails to have him complete this form and return it.

Q. What if the worker just spoke with someone at the office and said, "Last month I had an operation and it was $90. When do I get my money back from the company?"

What would happen in that case?

A. The worker would be informed that he would have to—they would have to complete a claim form and present the appropriate bill or bills to them [61] for reimbursement. No payment is made without supporting medical evidence or itemization of the expenses.

Q. Why is that?

A. Well, I think I can use an analogy of us driving to work and our car breaks down. Because we're in front of a gas station, we leave it and go to work on a bus and come back that evening and the fellow says to us, "That will cost you $950." Are you going to ask what was done or are you just going to pay him $950.

You need proof of a claim and the expenses and the type of expenses and services that were rendered. Just need supporting evidence before any monies could be paid to anyone.

Q. When would you normally receive that proof?

A. Well, I think it can go to the extreme. I know of cases, because I have been up at Electric Boat, when an individual was released from Lawrence and Memorial Hospital in New London, had to pass by the benefits area going home and would stop off with a bill. They maybe had received the anesthesia bill or the surgeon's bill while they were still in the hospital and on the way home dropped it off for [62] payment. That would be an unusual situation but has happened.

The other extreme would be where someone would get a bill and just sit on it. But today, I am sure they would be receiving all kinds of dime notices to get the bill paid, and if you had benefits coverage, why you would not process a claim to get your benefits, I wouldn't know what the reason would be.

Q. Usually though the worker would send in the form and have the information with the form?

A. That's correct.

Q. And that is what you would rely on and act on?

A. That's correct.

MR. JOHNSON: That is all the questions I have.

MS. McNOWN: No redirect.

Off the record.

(WHEREUPON, discussion was had off the record.)

FURTHER DEPONENT SAITH NOT.

SCHAAL DEP. EX. NO. 1
FOR ID., AS OF 9/7/83

PRUDENTIAL
The Prudential Insurance Company
of America

Prudential's Group Insurance Claim Philosophy

(a) Our objective is to pay benefits promptly and accurately, when due.

(b) Although insurance may be purchased by groups, claims are presented by individuals and each claim is given the consideration we would expect to receive on our own claim.

(c) We pay no more and no less than provided by the contract.

Our claim practices are consistent with this philosophy:

1. Claims will be evaluated only by trained, capable people under experienced supervision.

2. Policy provisions will be applied uniformly in all paypoints, according to corporate group insurance memoranda.

3. Claims will be processed promptly. If any delay in settlement is anticipated, the claimant will be so notified.

4. Benefits are negotiated before the contract is issued, not when the claim is presented. Benefits are either payable or not payable; reasonable doubt will be resolved in favor of payment.

5. Any questionable claim will be thoroughly investigated and fully documented before a decision is made.

6. Claim decisions will be based on factual information only; only factual information will be recorded in our claim files; and all information will be held in confidence.

7. Claim decisions will not be influenced by the amount at risk.

8. Where circumstances indicate, professional medical and legal advice will be sought and respected.

9. A claim which is not payable, or on which benefits are being discontinued, will, before action is taken, be reviewed at a higher level than that of the person authorized to pay the benefit.

10. Whenever benefits are not payable, the claimant will be given a prompt, complete explanation and will be told of our willingness to review based upon any pertinent additional information.

Medical information seen by any claim personnel, no matter who or where they are, is a confidential communication:

11. Only those with a **need to know** are entitled to review such information.

12. Medical information passing between doctor, hospital and Prudential cannot be released without proper authorization. If a claimant asks for information regarding the diagnosis, he should be instructed to contact his personal doctor for it.

13. When you ask for further information from a doctor or hospital, be as specific as possible as to what you need and why (if the reason isn't obvious).

14. Some people are relatively relaxed about discussing their own illness; others prefer to be close-mouthed. Claims are to be processed as though everyone were of the latter type.

In the Supreme Court of the United States

No. 85-1385

UNITED STATES, PETITIONER

v.

GENERAL DYNAMICS CORP., ET AL.

ORDER ALLOWING CERTIORARI. Filed June 16, 1986.

The petition herein for a writ of certiorari to the United States Court of Appeals for the Federal Circuit is granted.

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No. 85-1385

In the Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE UNITED STATES

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QUESTION PRESENTED

Whether a taxpayer using the accrual method of tax accounting is entitled to deduct, as a fixed liability at the close of its taxable year, an addition to a reserve for future expenses expected to be paid under an employee medical reimbursement plan, where the addition is based on the taxpayer's estimate of its liability to employees who were assumed to have received medical care during the year, but who had not submitted claims for payment, or whose claims for payment had been submitted but not approved, before the close of the taxable year.

PARTIES TO THE PROCEEDING

In addition to the parties named in the caption, Datagraphix, Inc., Material Service Corporation, Marblehead Lime Corporation, and General Dynamics Land Systems, Inc. (formerly Stromberg-Carlson Corporation), are respondents. Each is a wholly-owned subsidiary of General Dynamics Corporation.

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In the Supreme Court of the United States

OCTOBER TERM, 1986

No. 85-1385

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE UNITED STATES

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-5a) is reported at 773 F.2d 1224. The opinion of the Claims Court (Pet. App. 6a-18a) is reported at 6 Cl. Ct. 250.

JURISDICTION

The judgment of the court of appeals (Pet. App. 20a) was entered on September 19, 1985. On December 9, 1985, the Chief Justice extended the time within which to petition for a writ of certiorari to and including February 16, 1986 (a Sunday preceding a

federal legal holiday). The petition was filed on February 18, 1986, and was granted on June 16, 1986 (J.A. 179). The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTES AND REGULATIONS INVOLVED

The relevant portions of Sections 162, 446, and 461 of the Internal Revenue Code of 1954 (26 U.S.C. (& Supp. II)), and of Sections 1.446-1 and 1.461-1 of the Treasury Regulations on Income Tax (26 C.F.R.), are set forth at Pet. App. 21a-26a.

STATEMENT

1. For many years respondent General Dynamics Corporation and its subsidiaries have been required by collective bargaining contracts to maintain medical benefit plans for their employees.[1] Under these benefit plans, employees pay the first $100 of covered charges (generally called "the deductible") before becoming eligible for benefits. After that, employees generally are entitled to reimbursement for 80% of the covered medical costs that they or their dependents incur (J.A. 64). Certain items—such as expenses related to pregnancy and childbirth, the costs of footcare and eyeglasses, the costs of "checkup examina-

[1] The tax controversy at issue arises out of a single consolidated income tax return filed by General Dynamics Corporation on behalf of itself and its respondent subsidiaries. See Pet. App. 10a; Sections 1501-1505 of the Internal Revenue Code of 1954 (26 U.S.C.), as amended (the Code or I.R.C.). For convenience, we will use the term "respondent" to refer to the respondent corporations collectively. Although each corporation maintains its own medical benefits plan, there is no significant difference between the plans' respective modes of operation.

tions and tests not reasonably necessary to medical treatment"—are not covered by the plans (J.A. 54-56). In the case of otherwise-covered items, employees are not entitled to reimbursement if the treatment is for work-related injuries, if the treatment is furnished by an unapproved practitioner, if the expenses are incurred within 30 days of an employee's entry into the plan, or if the expenses are attributable to certain pre-existing conditions (J.A. 55, 56-57, 61, 162-164). The plans specify a maximum amount allowable per illness, a maximum amount allowable for each particular treatment or procedure, and a daily limit on hospital charges (J.A. 48-53, 63-77). The plans also specify that reimbursement will not be made for expenses in excess of the provider's usual charge for a particular treatment or procedure, or in excess of the customary charge prevailing in the neighborhood (J.A. 58, 160-161).

In order to obtain reimbursement under respondent's health plans, a covered employee must submit a claim for benefits on a standard form (Pet. App. 7a; J.A. 23). The claim must be accompanied by itemized bills evidencing the amount paid and specifying the diagnosis and treatment given (Pet. App. 7a-8a; J.A. 23). Respondent has no obligation to make any payment unless and until an employee has submitted a properly-documented claim for benefits and the claim has been determined to qualify for payment by respondent's claims examiner. See Pet. App. 7a-8a.

2. Prior to October 1, 1972, respondent supplied the health benefits outlined above by purchasing group medical insurance from two outside carriers, Aetna Life Insurance Company and Prudential Insurance Company. Insurance companies are generally required by state law to maintain certain "reserves"

with respect to the insurance coverage that they provide. In the case of the medical insurance coverage that Aetna and Prudential provided to respondent's employees, both companies prior to October 1, 1972, maintained reserves for health claims that they estimated (1) had arisen, but had not yet been reported to them, or (2) had been reported to them, but had not been processed or approved for payment (Pet. App. 8a). These reserves represented a statistical estimate, based on each carrier's past experience, of the amount that it would ultimately have to pay with respect to such actual or potential claims. Reserves of this sort are usually called "incurred but not reported," or "IBNR," reserves (*ibid.*). Under the special tax provisions applicable to insurance companies, an insurance company, unlike other taxpayers, is generally permitted to deduct additions to reserves (including IBNR reserves) that are required by state law. See I.R.C. § 807 (life insurance companies), § 832(b)(5) (casualty insurance companies).

On October 1, 1972, respondent became "a self-insurer of its medical care plan" (Pet. App. 2a, 7a). In other words, rather than purchasing insurance by the payment of premiums to outside carriers, respondent accepted the responsibility to pay employee medical claims out of its own funds. Although respondent thus ceased paying insurance premiums to Aetna and Prudential, those companies continued to administer the plans for a fee under service agreements (Pet. App. 7a). This shift to self-insurance entailed no change in the medical benefits provided to respondent's employees. From their perspective, the only difference was that their health-benefits checks thenceforth were drawn on a different bank and by a different payor. Respondent's shift to self-insurance likewise entailed no change in the claims-processing

procedure or in the personnel responsible for implementing it. Employees' claims continued to be screened in the first instance by the claims department at respondent's plants and then to be forwarded to the insurance company for evaluation and approval (*ibid.*).

In conjunction with its becoming a self-insurer, respondent agreed to accept responsibility for all as-yet-unfiled or unpaid claims arising out of medical services rendered before October 1, 1972. On that date, respondent took an amount equal to the aggregate IBNR reserves that Aetna and Prudential had previously maintained for those claims and set that amount up as a liability on its own books. On December 31, 1972, using statistics supplied by those companies, respondent calculated an estimate of its liability to employees who were assumed to have received medical care during the last three months of 1972, but who had not submitted claims, or whose claims had been submitted but not yet processed. The amount thus calculated was added to the beginning IBNR reserve balance that respondent had inherited from the insurance companies. Respondent then calculated the amount that it had actually paid out on approved claims during the final quarter of 1972. That amount was subtracted from the reserve balance. See Pet. App. 8a-9a; J.A. 27-33. These calculations (together with other minor adjustments) produced a year-end IBNR reserve balance in the amount of $5,575,289, representing respondent's estimate of its anticipated liability to pay benefits on claims arising from pre-1973 medical treatment (Pet. App. 10a; J.A. 33-34).

During 1973 and 1974, respondent actually paid out $4,583,893 in benefits on claims arising from pre-

1973 medical treatment (Pet. App. 16a). This sum was approximately $1 million (or 17.8%) less than the amount that respondent had reserved to pay such claims (*ibid.*). In the courts below, respondent presented no evidence that would indicate what portion either of its $5.5 million IBNR balance or of the $4.5 million actually paid represented medical treatment for which claims had not been filed as of December 31, 1972, as opposed to treatment for which claims had been filed but not yet processed.

It has been the experience of Aetna and Prudential that about 90% of the amounts for which respondent's employees claim reimbursement are actually approved for payment (Pet. App. 12a). As to the balance, the claims are rejected in whole or in part because they fail to qualify for reimbursement under the terms of the plans for one or more reasons. An expense would fail to qualify, for example, if the medical treatment were not a "covered service," if the employee's "deductible" had not been satisfied, if a specified maximum charge had been exceeded, or if the treatment were not deemed "medically necessary." See J.A. 48-57.

3. Respondent uses the accrual method of accounting for federal tax purposes. On its consolidated federal income tax return for calendar year 1972, respondent originally did not deduct any portion of its IBNR reserve in computing its tax. In 1977, however, after the IRS had commenced an audit of that return, respondent filed an amended return for 1972, claiming that it was entitled to deduct the 1972 year-end balance of its IBNR reserve ($5,575,289) as an ordinary and necessary business expense incurred during that taxable year. See I.R.C. § 162; J.A. 36.

The Commissioner denied respondent's claim for refund because the deduction sought for the IBNR reserve failed to satisfy the so-called "all events" test of tax accounting. That test provides that, under the accrual method of accounting, an expense may not be deducted until "all the events have occurred which determine the fact of the liability and the amount thereof can be determined with reasonable accuracy" (Treas. Reg. § 1.461-1(a)(2)). The Commissioner determined that the events that would fix respondent's liability to pay for a particular employee's medical treatment would be that employee's submission of a properly-documented claim for reimbursement, and respondent's determination that the claim qualified for payment, in some post-1972 tax year. Until those events occurred, the Commissioner concluded, respondent's obligation to pay was contingent and hence did not give rise to a deductible expense during the 1972 taxable year.

4. Following the denial of its administrative claim for refund, respondent filed this refund suit in the Claims Court, which ruled in its favor (Pet. App. 6a-18a). The court held that the last event necessary to fix respondent's liability to reimburse its employees occurs "when a qualified employee or dependent receives covered medical services" (*id.* at 11a, 13a). In the court's view, an employee's submission of a claim for benefits and respondent's evaluation of it with a view to determining whether or not it qualifies for payment constitute mere "clerical," "administrative," or "ministerial" steps that are not "condition[s] precedent to establishing the fact of liability" (*ibid.*). The court held, moreover, that respondent, in order to establish the fact of its liability, need not demonstrate "any specific liability to particular em-

ployees who received treatment" (*id.* at 9a). Rather, it was sufficient for respondent to "estimate [its] aggregate liability" to its employees as a group, basing its estimate on a statistical probability that a certain quantum of covered medical services had been rendered to covered recipients (*ibid.*). The court noted that respondent's method of computing its IBNR reserve "reflected accepted insurance company practice" and that "insurance companies can and do deduct such reserves" (*ibid.*). The court also ruled that, because respondent ultimately paid out 82.2% of the amount reserved, its estimate satisfied the "reasonable accuracy" prong of the "all events" test (*ibid.*). The court accordingly held that respondent was entitled to deduct the entire 1972 year-end balance of its IBNR reserve as a business expense "incurred during the taxable year" (I.R.C. § 162(a)).

The Federal Circuit affirmed (Pet. App. 1a-5a). The court stated that the issues had been "thoroughly treated in the trial court's opinion" and that the only question that it "need[ed] to address on appeal" was whether the decision below was contrary to Court of Claims precedent (*id.* at 1a-2a). The Federal Circuit answered that question in the negative and proceeded to "affirm * * * on the basis of the Claims Court opinion" (*id.* at 5a).

SUMMARY OF ARGUMENT

A. Taxpayers using the accrual method of accounting may not deduct business expenses until the year in which the obligation to pay has become "fixed and certain." See, *e.g.*, *United States* v. *Hughes Properties, Inc.*, No. 85-554 (June 3, 1986), slip op. 7. One of the major consequences of this tax accounting system is that, in the absence of special authoriza-

tion by Congress, a taxpayer is not entitled to take a current deduction for amounts set aside as reserves to cover anticipated future expenses, even though the use of such reserves is an accepted financial accounting practice. Reserve accounting, including the IBNR reserve that respondent seeks to deduct here, is useful in giving a picture of a corporation's financial condition, and it advances the principle of accounting conservatism by accruing liabilities as soon as they can be estimated, thereby erring on the side of understatement of income. Because this principle is in considerable tension with the goal of the tax system to protect the public fisc, and because the tax system demands certainty, not estimation, it has long been recognized that reserve accounting is generally unacceptable as a method of accounting for tax purposes. See generally *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. 522, 541-543 (1979).

Congress has, on occasion, given specific attention to whether the general rule against the use of reserve accounting should be modified. In the interest of establishing greater conformity between tax and financial accounting, the Internal Revenue Code of 1954 originally contained a provision allowing a deduction for additions to reserves for estimated expenses, a provision that would have permitted the deduction sought by respondent here. Indeed, the legislative history of that provision explicitly listed estimates of "certain liabilities for self-insured injury and damage claims" as among the expenses that could be deducted under it. See H.R. Rep. 1337, 83d Cong., 2d Sess. A163 (1954). However, Congress soon recognized that this acceptance of reserve accounting would have a disastrous impact on the government's revenue, and it repealed this provision

retroactively less than a year later, thereby restoring the status quo ante under which the deduction of reserves is not permitted. See generally *American Automobile Ass'n* v. *United States*, 367 U.S. 687, 694-697 (1961).

Since 1921, the Code has contained special provisions relating to the taxation of insurance companies, and these provisions permit life and casualty insurance companies to deduct IBNR reserves. Respondent is not an insurance company, however, and it is not entitled to the same special treatment simply because it mimicked insurance company practice in setting up its own IBNR reserve. This is so both because the terms of the Code limit the availability of this deduction to insurance companies and because the tax policies that underlie this exception have no application to companies like respondent that are not in the insurance business. See generally *Brown* v. *Helvering*, 291 U.S. 193, 201 (1934). On the contrary, the fact that Congress took special action to make these reserves deductible for insurance companies, coupled with the fact that Congress repealed a provision that would have made them deductible for all taxpayers, strongly suggests that respondent may not take a current deduction for its additions to its IBNR reserve in the absence of specific authorization by Congress. This reserve is little different from any other reserve established by a taxpayer in anticipation of probable future expenses, and it is clear under the Code that such reserves are not deductible because they do not represent a "fixed and certain" obligation to pay.

B. Respondent's attempt to deduct additions to its IBNR reserve clearly fails the "all events" test, which has been the standard for almost 60 years for

determining when an item of expense is to be regarded as "incurred" for federal tax purposes. The first part of the test provides that an expense may not be deducted until "all the events have occurred which determine the fact of the liability" (Treas. Reg. § 1.446-1(a)(2)). That standard is not satisfied here. Respondent's IBNR reserve is designed to estimate future liability for medical services obtained during the taxable year, but for which a claim either has not been filed, or has been filed but not yet processed or approved. Under the terms of its health plans, however, respondent is not required to make any reimbursement for medical services until both of these events occur—the filing of a claim and its approval for payment. Accordingly, the $5,575,289 estimate of future liability contained in respondent's reserve did not represent a "fixed and certain" obligation to make a payment.

An employee's receipt of medical services by itself creates no obligation on the part of respondent to pay reimbursement. It is true that respondent at that point reasonably can anticipate that it will have a future obligation to reimburse the employee if he files a claim and his claim is approved. But this anticipated obligation is no more certain than the future liability that respondent could have anticipated at the time it originally entered into the collective bargaining contracts under which the health plans were created. It was entirely possible that some of the employees who received medical services in 1972 would never file a claim—because of inadvertence, a desire to keep their employer from learning of certain medical conditions, or other reasons—and hence respondent would never be obligated to pay reimbursement for those expenses. Even as to

employees who had filed claims in 1972, moreover, it was by no means certain that the claims would be approved for payment. They could be denied in whole or in part if respondent determined that the charges were not reasonable or customary, that the services were not medically necessary, or that the treatment was for a preexisting condition. In short, until a claim for medical services is filed and is approved for payment by respondent, any reimbursement liability under the plans is contingent, not fixed and certain.

Moreover, the amount of respondent's IBNR reserve does not reflect any *actual* obligations, fixed or otherwise. Respondent's $5.5 million figure was not based on knowledge of even a single individual receipt of medical services; it was nothing more than an educated guess as to aggregate liability based on past experience. This sort of aggregate estimate is incompetent as a matter of law to "establish the fact of the liability" (Treas. Reg. § 1.446-1(c)(1)(ii)). A liability can become "fixed" and satisfy the "all events" test only when it is based on known facts respecting individual claimants. See *American Automobile Ass'n* v. *United States*, 367 U.S. at 692.

ARGUMENT

A RESERVE ESTABLISHED TO COVER THE ESTIMATED COST OF REIMBURSING EMPLOYEES FOR MEDICAL SERVICES ASSUMED TO HAVE BEEN RENDERED DURING THE TAXABLE YEAR, WHERE PAYMENT IS CONTINGENT UPON THE FILING AND PROCESSING OF QUALIFIED CLAIMS IN FUTURE YEARS, IS NOT AN EXPENSE "INCURRED DURING THE TAXABLE YEAR" AND HENCE CANNOT GIVE RISE TO A CURRENT BUSINESS-EXPENSE DEDUCTION FOR AN ACCRUAL-BASIS TAXPAYER

Respondent in this case seeks to take a current tax deduction for amounts set up as a reserve to cover estimated payments expected to be made to its employees in future years. In constructing this "IBNR reserve," respondent made no attempt to ascertain whether any employee had in fact received medical services before the close of its tax year. Nor did respondent endeavor to ascertain whether employees who had received medical services would seek or were seeking reimbursement for them. Rather, respondent's IBNR reserve represented a mere projection of its estimated liability, based on statistics concerning claims paid in past years and on the previous "lag time" between its employees' receipt of services and its insurers' tender of payment. See Pet. App. 9a & n.1. Respondent contends that the amount of this IBNR reserve—a reserve computed in precisely the same manner that life and health insurance companies compute their reserves—is an expense "incurred during the taxable year" (I.R.C. § 162(a)) that can be deducted currently by an accrual-basis taxpayer.

This contention flies in the face of long-recognized tax accounting principles. First and foremost, it erases the basic distinction between reserves set up

for financial accounting purposes to reflect anticipated future expenses and specific, identifiable obligations that are genuinely "fixed" within the meaning of the tax law. Second, it allows the current deduction of a particular type of reserve that Congress and the courts have indicated quite clearly is not available to ordinary accrual-basis taxpayers but rather is available only to insurance companies. Finally, respondent's contention rests on a serious misinterpretation of the "all events" test, which establishes two prerequisites to the accrual of an expense —"all the events [must] have occurred which determine the fact of the liability and the amount thereof [must] be determin[able] with reasonable accuracy" (Treas. Reg. § 1.461-1(a)(2)). The court of appeals' acceptance of respondent's contention marks a sharp departure from well-established rules of tax accounting—one that threatens a serious erosion of the fundamental principle that a taxpayer may not deduct, absent specific congressional authorization, reserves set up to cover contingent future expenses.

A. The Amount Of Respondent's Estimated Future Medical Reimbursements Is Not An Expense Incurred During The Taxable Year, But Rather Is A Reserve For Future Expenses That Cannot Be Currently Deducted Because Its Use For That Purpose Has Not Been Specifically Authorized By Congress

1. a. Section 162 of the Code allows a deduction for business expenses "paid" or "incurred" during the taxable year. A taxpayer who uses the "cash receipts and disbursements method" of accounting (I.R.C. § 446(c)(1)) is entitled to deduct business expenses only in the year in which they are paid. Treas. Reg. §§ 1.446-1(c)(1)(i), 1.461-1(a)(1). A taxpayer who uses the "accrual method" of accounting (I.R.C. § 446(c)(2)), as respondent does, is en-

titled to deduct expenses in the year they are "incurred" regardless of when the expenses are actually paid. Treas. Reg. § 1.461-1(a)(2); see *United States* v. *Anderson*, 269 U.S. 422, 424 (1926). It is well settled that " 'to incur' means to become liable or subject to." *Ox Fibre Brush Co.* v. *Blair*, 32 F.2d 42, 47 (4th Cir. 1929), aff'd *sub nom. Lucas* v. *Ox Fibre Brush Co.*, 281 U.S. 115 (1930). "[A] liability does not accrue as long as it remains contingent," even if it is quite probable that an obligation to pay the liability will become fixed in the near future. *Brown* v. *Helvering*, 291 U.S. 193, 200 (1934). See, *e.g.*, *United States* v. *Hughes Properties, Inc.*, No. 85-554 (June 3, 1986), slip op. 6-7; *Dixie Pine Co.* v. *Commissioner*, 320 U.S. 516, 519 (1944). " 'The tax law requires that a deduction be deferred until "all the events" have occurred that will make it fixed and certain.' " *United States* v. *Hughes Properties, Inc.*, slip op. 7 (quoting *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. 522, 543 (1979)).

One of the major consequences of this tax accounting system is that taxpayers ordinarily are not entitled to take current deductions for amounts set aside as reserves to cover anticipated future expenses. Such reserves are of course a common and entirely appropriate feature of commercial or financial accounting. Reserve accounting attempts to paint an accurate picture of a company's financial condition by reporting the anticipated results of transactions at the end of a given year, even though the transactions may not be complete and even though those results must be estimated. This is done through the use of an ongoing reserve account to accumulate estimates of aggregate expenses expected to be paid in the future, correcting in subsequent years the errors

inherent in predicting future events.[2] Accepted financial accounting principles encourage the practice of using reserves to cover estimates of future expenses that probably will be incurred. See generally H. Finney & H. Miller, *Principles of Accounting, Interme-*

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[2] Mechanically, a reserve is nothing more than an entry in an accounting record. *Geyer, Cornell & Newell, Inc.* v. *Commissioner*, 6 T.C. 96, 100 (1946). In the first year a reserve is used, the estimated expense is deducted from revenues and is added to the reserve account, which is carried as a liability on the company's balance sheet. The effect of this is to reduce the company's reported income for year one. In a subsequent year, when the previously estimated expense is finally paid, the actual cost incurred is charged to (removed from) the reserve instead of being charged as an expense against that year's income. Any differences between the actual amount paid and the estimated amount is accounted for at the end of the later year. See, *e.g.*, *Levelland Savings & Loan Ass'n* v. *United States*, 421 F.2d 243, 247 (5th Cir. 1970); *Hawes Corp.* v. *Commissioner*, 44 T.C. 705, 707-709 (1965). At the end of each succeeding year, the total amount of estimated liability is compared to the reserve balance. If the former exceeds the latter, an addition is made to the reserve, and is treated as an expense in that year, in the amount necessary to bring the reserve balance up to the total amount of estimated liability. Conversely, if the reserve balance exceeds the total amount of estimated liability, the reserve is reduced accordingly, and the amount of the reduction is taken into income. Because additions to and reductions of the reserve represent the difference between the amount of estimated liability and the reserve balance, the reserve is self-correcting over time; excessive estimates in a prior year are corrected by recording a smaller expense for additions to the reserve in subsequent years. See, *e.g.*, *Bird Management, Inc.* v. *Commissioner*, 48 T.C. 586, 595-597 (1967); *Calavo, Inc.* v. *Commissioner*, 304 F.2d 650, 654 (9th Cir. 1962). A reserve thus does not operate to increase the amount of an expense but rather to accelerate the time at which the expense is offset against income. See *Knight-Ridder Newspapers* v. *United States*, 743 F.2d 781, 799 (11th Cir. 1984).

diate 381-390 (7th ed. 1979). Indeed, in order to advance "the principle of conservatism," financial accounting rules "typically require that a liability be accrued [by establishing it on the books as a reserve] as soon as it can reasonably be estimated." *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. at 541, 542. See, *e.g.*, *Commissioner* v. *Hansen*, 360 U.S. 446, 448 (1959) (reserve to cover contingent liability in event of nonperformance of guarantee); *Brown* v. *Helvering*, 291 U.S. at 196-197 (reserve to cover expected liability in likely event of insurance policy cancellations); *Lucas* v. *American Code Co.*, 280 U.S. 445, 447 (1930) (reserve to cover contingent liability on contested lawsuit). The effect of reserve accounting is thus to accelerate expenses into the *earliest* year in which it is possible to make a reasonable prediction that those expenses will occur, with a corresponding reduction in income as reported for financial accounting purposes for the year in question.

Although reserve accounting is indisputably a legitimate and useful method of financial accounting,[8] it is as a rule inconsistent both with the overall objective and with the practical operation of the accrual method of accounting used for tax purposes. Under the tax accrual method, the goal is to assign to each taxable year the individual items of income and deductions that the taxpayer has become entitled to receive or has become obligated to pay. That accrual method does not allow reporting of any par-

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[8] This Court has referred to the use of a reserve as a "method of accounting." *Nash* v. *United States*, 398 U.S. 1, 2 (1970); *Brown* v. *Helvering*, 291 U.S. at 197. See also *Knight-Ridder Newspapers* v. *United States*, 743 F.2d at 797-800; H.R. Rep. 1337, 83d Cong., 2d Sess. 48-49 (1954); S. Rep. 1622, 83d Cong., 2d Sess. 300 (1954).

ticular item until the right to receive it or the obligation to pay it has become fixed and certain. It is this certainty that makes the accrual method acceptable for tax accounting. By the same token, the uncertainty of reserve accounting, which relies on the aggregation of estimates of future expenses and the correction in subsequent years of the errors inherent in making such predictions, renders that method unacceptable for tax purposes.

It is well settled that reasonable financial accounting methods are often impermissible under the tax law. To say that a taxpayer's accounting practice " 'is in accord with generally accepted commercial accounting principles,' " this Court has observed, "is not to hold that for income tax purposes it so clearly reflects income as to be binding on the Treasury." *American Automobile Ass'n* v. *United States*, 367 U.S. 687, 693 (1961) (footnote omitted). In particular, this Court has long recognized that reserve accounting is generally unacceptable in computing taxable income. In the words of Justice Brandeis, speaking for the Court: "The prudent business man often sets up reserves to cover contingent liabilities. But they are not allowable as deductions." *Lucas* v. *American Code Co.*, 280 U.S. at 452 (footnote omitted).

The Court recently reconfirmed and elaborated upon this proposition, emphasizing "the vastly different objectives that financial and tax accounting have." *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. at 542. "The primary goal of financial accounting is to provide useful information to management, shareholders, [and] creditors" and thereby "to protect these parties from being misled" (*ibid.*). Moreover, "financial accounting has as its foundation the principle of conservatism, with its corollary that 'pos-

sible errors in measurement [should] be in the direction of understatement rather than overstatement of net income'" (*ibid.*, quoting AICPA Accounting Principles Board, *Statement No. 4, Basic Concepts and Accounting Principles Underlying Financial Statements of Business Enterprises* ¶ 171 (1970)). Therefore, "accounting principles typically require that a liability be accrued as soon as it can reasonably be estimated" (439 U.S. at 543 (footnote omitted)). By contrast, "[t]he primary goal of the income tax system * * * is the equitable collection of revenue; the major responsibility of the Internal Revenue Service is to protect the public fisc" (*id.* at 542). These missions, the Court explained, are incompatible with financial accounting techniques, such as reserves, that are skewed toward understatement of income. The Court accordingly concluded that, "[g]iven this diversity, even contrariety, of objectives, any presumptive equivalency between tax and financial accounting would be unacceptable" (*id.* at 542-543 (footnote omitted)). Of particular relevance to the instant case, the Court noted that "divergence between tax and financial accounting is especially common when a taxpayer seeks a current deduction for estimated future expenses or losses" (*id.* at 541) —the precise situation involved here.

b. This Court's frequent pronouncements about the differences between tax and financial accounting, particularly concerning the use of reserves, have long sounded a doleful chord in taxpayers' ears, and 32 years ago, they briefly won relief from Congress. As this Court pointed out in *American Automobile Ass'n, supra*, Congress in 1954 temporarily adopted provisions that would have permitted deferral of income (Section 452 of the Code) as well as the deduction of anticipated expenses (Section 462 of the Code) by

the use of the reserve method of accounting employed by respondent here. See 367 U.S. at 694-697. Section 462 authorized a deduction by accrual-basis taxpayers of "a reasonable addition to [a] reserve for estimated expenses," with "estimated expenses" being defined to include deductions "attributable to the income of the taxable year or prior taxable years." Internal Revenue Code of 1954, ch. 736, § 462(a) and (d)(1)(B), 68A Stat. 158-159. See *id.* § 452(a), 68A Stat. 152 (companion provision permitting deferral of prepaid income). Section 462 was designed to bring "[t]ax accounting * * * more nearly in line with accepted business accounting * * * by allowing reserves to be established for known future expenses." S. Rep. 372, 84th Cong., 1st Sess. 3 (1955). Congress explained that Section 462 would allow taxpayers to deduct estimated amounts of "certain liabilities for self-insured injury and damage claims," exactly the types of claims at issue here. H.R. Rep. 1337, 83d Cong., 2d Sess. A163 (1954); S. Rep. 1622, 83d Cong., 2d Sess. 63, 305-307 (1954).

The radical change brought about by Sections 462 and 452 was short-lived. Congress repealed those provisions retroactively less than one year later, prompted by warnings from the Treasury Department "that the proposed endorsement of such [methods of] accounting would have a disastrous impact on the Government's revenue." *American Automobile Ass'n* v. *United States*, 367 U.S. at 695. See Act of June 15, 1955, ch. 143, §§ 1, 3, 69 Stat. 134-135.[4] The taxpayer in *American Automobile Ass'n* contended that Congress's retroactive repeal of these

[4] The Treasury Department had revised upward its projection of estimated revenue loss due to these provisions from $47 million to $1 billion. H.R. Rep. 293, 84th Cong., 1st Sess. 3 (1955).

provisions should not be interpreted to preclude use of the reserve method of accounting that it employed, but the Court held that this contention " 'varnish[ed] nonsense with the charm of sound' " (367 U.S. at 695). "[T]he cold fact," the Court said, "is that [Congress] repealed the only law incontestably permitting the practice upon which the [taxpayer] depends" (*ibid.*). In terms equally appropriate to the instant case, this Court characterized the retroactive repeal of Sections 452 and 462 as "a mandate from the Congress that [the taxpayer's] system was not acceptable for tax purposes. To interpret its careful consideration of the problem otherwise is to accuse the Congress of engaging in sciamachy." 367 U.S. at 695-696.

Congress thus has specifically considered and, upon reconsideration, rescinded a provision that would have allowed tax deductions for reserves established in accordance with generally accepted financial accounting principles. And there can be no doubt that the $5.5 million reserve for which respondent seeks a deduction here is precisely the sort of reserve that Congress had in mind in 1954. The Claims Court, though it allowed respondent to deduct additions to the IBNR account, recognized that it was an ordinary reserve. See Pet. App. 8a-9a, 13a-14a, 16a-17a. Indeed, the IBNR account was literally taken off the books of the insurance companies, where it was indubitably a reserve, and placed upon respondent's own books. The amount contained in the IBNR reserve does not reflect any knowledge on respondent's part of the numerous future liabilities (in the form of potential claims for reimbursement) that the account is designed to represent. Rather, it is purely an estimate (and a poor one at that, being off by approximately $1 million) derived from a statistical

analysis of claims that had been paid in the past by respondent's insurers and of the "lag time" that in the past had typically intervened between its employees' receipt of medical services and the insurers' tender of reimbursement. See Pet. App. 8a-9a & n.1.

It is of course likely that history will repeat itself, more or less, and respondent's estimate of its probable future liability may be quite a useful thing for financial accounting purposes. But it simply does not represent an "incurred" expense that can form the basis for an income tax deduction in the year the estimate is placed on the books of the corporation. As this Court explained in *Thor Power Tool Co.*, 439 U.S. at 543, "[f]inancial accounting * * * is hospitable to estimates, probabilities, and reasonable certainties; the tax law, with its mandate to preserve the revenue, can give no quarter to uncertainty." "[R]easonable estimates may be useful, even essential, in giving shareholders and creditors an accurate picture of a firm's overall financial health; but the accountant's conservatism cannot bind the Commissioner in his efforts to collect taxes" (*ibid.*). The words that Justice Brandeis penned for the Court in 1934 are thus equally true today: "Only a few reserves voluntarily established as a matter of conservative accounting are authorized by the Revenue Acts." *Brown* v. *Helvering*, 291 U.S. at 201-202.

2. a. As Justice Brandeis intimated, of course, the general rule that accounting reserves are unacceptable for tax purposes yields in those instances where Congress has explicitly authorized particular categories of taxpayers to use reserves for specified purposes. Since 1939, for example, the Code has provided that taxpayers in general shall "be allowed (in the discretion of the Secretary) a deduction for a

reasonable addition to a reserve for bad debts." I.R.C. § 166(c); see Internal Revenue Code of 1939, ch. 1, § 23(k)(1), 53 Stat. 13. The Code currently authorizes somewhat more generous bad debt reserves for banks and S&L associations. See I.R.C. §§ 585, 586, 593.[5] And of particular relevance to the present case, the Code for over 60 years has authorized the use of various types of reserves, including IBNR reserves, by insurance companies. Because respondent is not an "insurance company," these provisions strongly suggest that the deduction respondent seeks for its IBNR reserve is impermissible.

In 1921, Congress concluded that the then-existing system of taxing insurance companies under the same provisions applicable to other corporations was unsatisfactory. Accordingly, Congress established special provisions for the taxation of life insurance companies (Revenue Act of 1921, ch. 136, §§ 242-245, 42 Stat. 261) and other insurance companies (*id.* §§ 246-247, 42 Stat. 262-263). These provisions have been amended on numerous occasions on the road to their present incarnation in Subchapter L (I.R.C. §§ 801-845), but at all times since 1921 insurance companies have been taxed under provisions inapplicable to other enterprises.[6]

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[5] This venerable exception to the general prohibition against the use of reserves for tax purposes appears likely to be narrowed soon. The House version of the 1986 tax reform bill would eliminate the availability of bad-debt reserves for banks with assets in excess of $500 million, and news reports indicate that that provision has been retained by the Conference Committee. See H.R. 3838, 99th Cong., 1st Sess. § 801 (1985); N.Y. Times, Aug. 18, 1986, at B7.

[6] See generally Tye, *Taxation of Insurance Companies*, 2 Tax L. Rev. 509 (1947); Vickrey, *Insurance Under the Federal Income Tax*, 52 Yale L.J. 554 (1943); *Alinco Life Ins. Co.* v. *United States*, 373 F.2d 336, 345-348 (Ct. Cl. 1967).

Significantly, Subchapter L contains some of the few instances in which the Code specifically authorizes the use of reserve accounting. Section 807 provides in detail for the use of reserves—generally required and regulated by state law—by "life insurance companies" as defined in Section 816. See I.R.C. §§ 807, 816(a) and (b). Casualty insurance companies are similarly entitled to deduct reserves set up in accordance with standard industry practice to cover "unpaid losses" suffered during the taxable year. See I.R.C. § 832(b)(5); Treas. Reg. § 1.832-4(b) (requiring casualty insurance companies to satisfy the Commissioner that reserves for unpaid losses reflect "amounts which, based upon the facts in each case and the company's experience with similar cases, can be said to represent a fair and reasonable estimate of the amount the company will be required to pay"). Specifically, the "incurred but not yet reported" or "IBNR" reserves generally maintained by casualty insurance companies may be deducted by those companies pursuant to Subchapter L. See generally *Maryland Savings-Share Ins. Corp.* v. *United States*, 644 F.2d 16, 24-25 (Ct. Cl. 1981). In the instant case, for example, the Claims Court noted that, "[p]rior to October 1, 1972, Aetna and Prudential deducted their IBNR reserves in the taxable year [in which] the [medical] services were received" by respondent's employees. Pet. App. 8a.

Thus, the Code does provide special authorization *for insurance companies* to use reserves analogous to the one that respondent seeks to deduct here. Although the courts below adverted to this fact, they refused to draw the negative inference that we believe should properly be drawn from it. The Claims Court noted that respondent's method of computing

its IBNR reserve "reflected accepted insurance company practice" and that "insurance companies can and do deduct such reserves" (Pet. App. 9a). That is certainly true and, indeed, is something of an understatement. Respondent did not merely compute its reserve in accordance with accepted insurance company practice; it established its IBNR account by literally transferring to its own books the precise amount that its insurers had previously maintained in *their* IBNR reserves in connection with respondent's policies.[7] And in augmenting its IBNR reserve at the end of the year, respondent added an amount that was explicitly based on the recommendations of its former insurers. Pet. App. 8a-9a & n.1.

But the fact that respondent has rather accurately mimicked insurance company practice in setting up its IBNR account does not entitle it to a tax deduction. The Code expressly limits to insurance companies the authorization to deduct insurance reserves, and respondent, as it concedes (Br. in Opp. 22), is not an "insurance company." The fact that the Code makes special provision for insurance companies to deduct these reserves strongly suggests that they are not generally deductible by other taxpayers, else the special provision for insurance companies would be

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[7] When respondent terminated its outside insurance policies and made the shift to self-insurance, its insurers paid to it the funds represented by the initial IBNR reserve amount in return for respondent's assumption of the potential liability for the claims reserved against. Although the record is silent on the matter, respondent stated in the court of appeals (C.A. Br. 48 n.**) that this amount was included in its taxable income, apparently as a refund of insurance premiums that it had previously paid to the insurance companies and deducted on its tax returns. See *Hillsboro Nat'l Bank* v. *Commissioner*, 460 U.S. 370 (1983).

superfluous. Hence, the very fact that respondent's IBNR reserve is a copy of those maintained by insurance companies provides weighty evidence that the court of appeals erred in allowing respondent to take a current deduction for additions to that reserve.

b. This Court has long recognized that ordinary taxpayers may not avail themselves of the specialized treatment that the Code has conferred on insurance companies. In *Brown* v. *Helvering*, *supra*, the Court rejected the taxpayer's claim that he was entitled to take a deduction for anticipated "return premium" expenses—a deduction that the Code explicitly made available to insurance companies. "The simple answer," the Court explained, "is that the [taxpayer] is not an insurance company; * * * the deductions allowed for additions to the reserves of insurance companies are technical in character and are specifically provided for in the Revenue Acts" (291 U.S. at 201).

The principle enunciated in *Brown* v. *Helvering*, *supra*, has also been applied by numerous lower courts that have refused to permit taxpayers to deduct additions to so-called "self-insurance" reserves.[8] A taxpayer that wishes to provide against potential future liabilities generally has two options at its disposal. It may purchase insurance from an outside carrier, the purchase price being represented by the obligation to pay annual premiums. If the taxpayer is unable to acquire insurance from an outside carrier, or if it believes such insurance to be too expensive, it may elect instead to "self-insure," that is, to undertake to

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[8] The term "self-insurance," of course, is strictly speaking an oxymoron, since it is impossible for a person to "insure" himself. See generally *Helvering* v. *Le Gierse*, 312 U.S. 531 (1941).

discharge future liabilities out of its own funds. In the latter event, the taxpayer's undertaking will typically be reflected on its balance sheet by a reserve account set up to cover those estimated future costs.

When a taxpayer elects to buy insurance from an outside carrier, the premiums paid or incurred are of course deductible currently as business expenses. See I.R.C. § 162; Treas. Reg. § 1.162-1(a) ("Among the items included in business expenses are * * * insurance premiums against fire, storm, theft, accident, or other similar losses."). When a taxpayer elects to "self-insure," on the other hand, the courts have consistently denied deductions for additions to the self-insurance reserve, reasoning that the taxpayer has not externalized or "shifted" the risk of loss to another party by the payment of premiums, and that the taxpayer has not parted with anything by establishing a mere "reserve account" on its books. See, *e.g.*, *Steere Tank Lines, Inc.* v. *United States*, 577 F.2d 279 (5th Cir. 1978), cert. denied, 440 U.S. 946 (1979). And the courts have reached the same result where a corporate taxpayer undertakes to pay purported "premiums" to a wholly-owned or "captive" insurance company, correctly reasoning that there is no externalization or distribution of risk given the identity of interests between the so-called "insurer" and so-called "insured." See, *e.g.*, *Beech Aircraft Corp.* v. *United States*, No. 84-2658 (10th Cir. Aug. 6, 1986); *Carnation Co.* v. *United States*, 640 F.2d 1010 (9th Cir.), cert. denied, 454 U.S. 965 (1981). See generally Rev. Rul. 77-316, 1977-2 C.B. 53; Bradley & Winslow, *Self-Insurance Plans and Captive Insurance Companies—A Perspective on Recent Tax Developments*, 4 Am. J. Tax Pol'y 217 (1985); O'Brien & Tung, *Captive Off-Shore Insurance Corporations*, 31 N.Y.U. Inst. Fed. Tax'n 665 (1973).

c. The precept that the special treatment accorded by the Code to insurance companies cannot be extended by analogy to other taxpayers is thus well established in this Court's decisions and in the decisions of the lower courts. This distinction between "insurance" and "self-insurance," moreover, is not merely a technical one, but is rooted in the fundamental policy goal of obtaining an accurate statement of income for tax purposes. The legislative history of the short-lived Section 462 of the 1954 Code demonstrates that Congress did not view "self-insurers" as at all analogous to insurance companies. Both committee reports listed estimates of "certain liabilities for self-insured injury and damage claims" as among the expenses that the now-repealed Section 462 was meant to permit taxpayers to deduct. H.R. Rep. 1337, *supra*, at A163; S. Rep. 1622, *supra*, at 63, 305-307. Clearly, Congress's view was that reserves for estimated expenses could not have been accrued by ordinary taxpayers before the enactment of Section 462, and the calculated repeal of that Section was "a mandate from the Congress" that an accounting method entailing such reserves "was not acceptable for tax purposes" (*American Automobile Ass'n* v. *United States*, 367 U.S. at 695).

The reasons why self-insurers like respondent should not be given the benefit of reserve deductions available to insurance companies are fairly clear. "Self-insurance is not the equivalent of insurance" (*Beech Aircraft Corp.* v. *United States*, slip op. 5), and respondent is not like an insurance company at all. It is subject neither to state regulation that applies to insurance companies nor to the provisions of the Internal Revenue Code that generally apply to such companies. It is not engaged in the insurance

business of spreading risk among various policyholders. See *Helvering* v. *Le Gierse*, 312 U.S. 531, 539 (1941). Rather, it simply has undertaken as part of its collective bargaining agreement to provide certain health benefits to its employees as a wage substitute. Respondent could provide those benefits through a conduit by taking out an insurance policy, but instead it has chosen, by becoming a "self-insurer," to provide the benefits directly.

More importantly, the peculiarities of insurance companies that impelled Congress to give them special tax treatment, including the right to use IBNR reserves, do not apply to ordinary taxpayers like respondent. An insurance company receives large amounts of income in the form of premium payments. The company does not have unrestricted use of those funds, however, because state law requires it to reserve a substantial portion in order to pay future claims under the policies for which the premiums have been paid. If the Code did not permit the company to accrue the additions to its IBNR reserve, the result would be an unrealistic overstatement of income in the year the premiums were received because of the inclusion of all of the premium income without any offset for related expenses. See *Bituminous Casualty Corp.* v. *Commissioner*, 57 T.C. 58, 77 (1971). This mismatching problem plainly is not found in the case of a self-insurer like respondent, who receives no premium income and is not subject to analogous state law restrictions on the use of its funds. Rather, the IBNR reserve established by respondent is little different from any other reserve established by a taxpayer in anticipation of probable future expenses, and respondent should not be able to take a current deduction for additions to that reserve.

B. Respondent's Attempt To Deduct Additions To Its IBNR Reserve Fails The "All Events" Test

In its brief in opposition, respondent professes to disagree with few of the general propositions that we have outlined above. Respondent concedes that its IBNR account is a garden-variety reserve, that taxpayers generally are precluded from deducting self-insurance reserves, and that it cannot avail itself of the special provisions permitting IBNR reserves to be deducted by insurance companies. See Br. in Opp. 21-22. Respondent contends, however, that these propositions are irrelevancies in the instant case, asserting that its particular IBNR reserve also happens to qualify for deduction under the "all events" test governing deductions by accrual-basis taxpayers generally.

In light of the general hostility of the tax system to the use of reserves, and in light of Congress's specific decisions to authorize the use of IBNR reserves by insurance companies and to rescind a short-lived provision that would have allowed other taxpayers to use them, respondent's contention should be greeted at the threshold with a healthy degree of skepticism. In any event, we shall demonstrate that respondent's contention is incorrect. The idea that any taxpayer has always been free to deduct an IBNR reserve under the general standard applicable to accrual-basis taxpayers—an idea that respondent convinced the courts below to accept—rests on a serious misapplication of the "all events" test. Applied correctly, the test confirms that respondent is not entitled to take a current deduction for its estimate of its potential future liabilities. In the words of the Tax Court, the deduction of casualty insurance reserves by ordinary accrual-basis taxpayers is "fundamentally at odds

with the 'all events' test." *Bituminous Casualty Corp.* v. *Commissioner*, 57 T.C. at 77.

1. The "all events" test has been the standard for determining when an item of expense is to be regarded as "incurred" for federal tax purposes for almost sixty years. The test originated in *United States* v. *Anderson*, 269 U.S. at 441, where this Court stated that an expense may be accrued in the year in which "all the events * * * occur which fix the amount * * * and determine the liability of the taxpayer to pay it." The "all events" test has since been incorporated in the Treasury Regulations. See Treas. Reg. § 1.446-1(c)(1)(ii) (accruals in general), § 1.451-1(a) (accrual of income), § 1.461-1(a)(2) (accrual of deductions). The test has come to ~~the~~ be recognized as "a fundamental principle of tax accounting" and as " 'the "touchstone" for determining the year in which an item of deduction accrues.' " *United States* v. *Hughes Properties, Inc.*, slip op. 6 (quoting *United States* v. *Consolidated Edison Co.*, 366 U.S. 380, 385 (1961)).[9]

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[9] In 1984, Congress set forth for the first time a statutory definition of the "all events" test, providing that "the all events test is met with respect to any item if all events have occurred which determine the fact of liability and the amount of such liability can be determined with reasonable accuracy." Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 91(a), 98 Stat. 598-601 (adding I.R.C. § 461(h)(4)). This definition, of course, accords with that previously enunciated by this Court and by the Treasury Regulations. This definition was enacted as part of a broader amendment designed to establish more specific rules for accrual of deductions—rules that entail postponement of the accrual of some deductions that might be held to satisfy the "all events" test—by requiring that expenses generally not be accrued until "economic performance" has occurred. I.R.C. § 461(h) and (i). Section 461(h)(1) of the Code now provides that, "in determining whether an amount has been incurred with

The "all events" test has two elements, both of which must be satisfied before accrual of an expense is proper. First, "all the events [must] have occurred which establish the fact of the liability giving rise to [the] deduction" (Treas. Reg. § 1.446-1(c)(1)(ii)). Second, the amount of the deduction must be capable of being "determined with reasonable accuracy" (*ibid.*). The second part of the test permits a degree of computational flexibility. See *Lucas* v. *American Code Co.*, 280 U.S. at 450; Treas. Reg. § 1.461-1(a)(2). But the Regulations emphasize that the first part of the test is absolute: "no accrual shall

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respect to any item during any taxable year, the all events test shall not be treated as met any earlier than when economic performance with respect to such item occurs." Where the taxpayer's liability arises from the provision of goods or services, or from the use of property, "economic performance" is generally deemed to occur when the goods or services are actually provided, or when the property is actually used (I.R.C. § 461(h)(2)(A) and (B)). Where the taxpayer's liability arises from a workers' compensation statute or tort, "economic performance" is deemed to occur when payments to the recipient are actually made (I.R.C. § 461(h)(2)(C)). The 1984 Act makes an exception to this general rule for "certain recurring items" (I.R.C. § 461(h)(3)). Such items may be deducted in the year preceding economic performance if the "all events" test is met and if several other conditions specified in the statute are satisfied—including the requirement that economic performance actually occur within a "reasonable period" (typically, 8½ months) after the close of the tax year. These provisions, which are generally effective for post-1983 tax years (Pub. L. No. 98-369, § 91(g), 98 Stat. 608), have no application to the instant case, which involves respondent's tax liability for 1972. The decision in this case, however, will be highly relevant to the administration of the new provisions because the applicability of the "recurring items" exception turns in part on whether the "all events" test is met.

be made in any case [unless] all of the events have * * * occurred which fix the liability" (*ibid.*).

This Court has used various phrases to describe the effect of the "all events" test. To be deductible for federal tax purposes, "the obligation to pay [must] ha[ve] become final and definite." *Security Flour Mills Co.* v. *Commissioner*, 321 U.S. 281, 287 (1944). It must be "fixed and absolute." *Brown* v. *Helvering*, 291 U.S. at 201. It must be "unconditional." *Lucas* v. *North Texas Lumber Co.*, 281 U.S. 11, 13 (1930). And, more recently, the Court has explained that a deduction must be deferred "until all the events have occurred that will make it fixed and certain." *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. at 543 (original quotation marks omitted). See generally *United States* v. *Hughes Properties, Inc.*, slip op. 6-7.

Regardless of the formulation chosen, respondent's contention that it can deduct additions to its IBNR reserve simply does not satisfy the necessary conditions. It clearly fails the first part of the "all events" test.[10] This failure is manifest when one considers the multiple events that had to occur before respondent had any "fixed obligation" to reimburse its em-

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[10] We note that it is highly questionable whether respondent's claimed deduction meets the second part of the "all events" test either. The disparity between the estimated liability of $5,575,289 and respondent's actual payments of $4,583,893 is approximately $1 million. See Pet. App. 16a. We do not agree that an estimation error of nearly 20% for amounts of this magnitude is a determination "with reasonable accuracy" within the meaning of the "all events" test. Although the courts below rejected our contention in this respect, we have not presented the "reasonable accuracy" issue for this Court's review because of the essentially factual nature of that question. See Pet. 13 n.2.

ployees—a chain of events that was not complete until after respondent's 1972 tax year closed.

When respondent originally entered into its collective bargaining contracts, it could reasonably have assumed, as a matter of probability, that it would ultimately have to pay out substantial sums to reimburse employees for medical services that they would incur. It might have been prudent for respondent to set up a reserve on its books at that time in order to reflect its duty to pay reimbursement over the life of the contracts. But respondent was plainly under no obligation to pay reimbursement to anyone when it signed the contracts, and it thus could not properly have accrued such a liability at that time.

When respondent closed the books on its 1972 tax year, it again reasonably assumed, as a matter of probability, that some of its employees had gone to the doctor during 1972 without yet being reimbursed, and that it would ultimately have to reimburse them for the medical services that they presumably had received. It was thus prudent for respondent to establish a reserve on its books in order to reflect its probable liability to pay those estimated sums in post-1972 tax years. But respondent at the close of 1972 still had no obligation to pay anyone the amounts reflected in its IBNR reserve. On our view, therefore, respondent could not properly accrue such a liability then, any more than it could properly have accrued such a liability when it signed the collective bargaining contracts to begin with.

When respondent subsequently learned that some of its employees had in fact gone to the doctor during 1972, that information would have further increased the probability that respondent would ultimately have to pay some reimbursement, and it perhaps would have given respondent data from which to estimate

its potential liability more accurately. But respondent at that time still had no obligation to make any payment to anyone. Rather, under the terms of the health plans established pursuant to the collective bargaining contracts, respondent had no obligation to pay, and did not in fact pay, any reimbursement unless and until (1) an employee submitted a claim complete with supporting documentation and (2) respondent and its agents processed the claim and thereby satisfied themselves that the claim qualified for payment in a determinable amount. Until these two events occurred, respondent had no "fixed and certain" obligation to pay out any funds. And as to every putative obligee-employee reflected in the IBNR reserve at the end of 1972, one or both of these conditions had not yet been met.

Many of the employees that respondent assumed to have received medical services during 1972 had not submitted any claim for reimbursement before the year ended. See Pet. App. 8a. It was entirely possible, moreover, that some of those employees would never submit a claim at all. Some might regard the medical expenses that they had incurred as too insignificant to warrant the trouble of seeking reimbursement. Some might prefer that their employer's agents not learn that they had undergone treatment for certain medical conditions. And some might fail to submit claims because of inadvertence or neglect. In all of these instances, respondent would never be required to make reimbursement because it was not obliged to pay until an employee filed a claim in writing supported by appropriate documentation. Respondent's obligation to reimburse employees who had received medical services in 1972, but who had submitted no claims before the year ended, was thus

neither "unconditional" nor "absolute" as of December 31, 1972.[11]

The fact that an employee's filing of a claim is one of the events necessary to "establish the fact of liability" under respondent's health plans is alone enough to require the rejection of any IBNR reserve deduction. That deduction also fails, however, because there is yet one additional and final event that must occur before the health plans create a fixed obligation to pay—the approval of the claim for payment after consideration and investigation by respondent and its agents. Once an employee has actually submitted a claim, respondent maintains the right to refuse reimbursement on numerous grounds. Claims can be denied, inter alia, on the ground that the treatment was not covered by the health plans, that the treatment was not "medically necessary," that the charges exceeded those that are reasonable and customary, that the illness for which the treat-

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[11] Indeed, the testimony of respondent's own witness demonstrates that respondent had no obligation to reimburse employees until a claim was actually filed. J. David Loftus, a claim administrator for Aetna, testified that respondent's plan generally provided time limits of 90 days for the filing of some claims and one year for the filing of other claims (J.A. 130). He further testified that claims filed outside this time period were usually processed in normal fashion if filed within two years of the medical treatment, but that claims filed later were usually questioned (J.A. 130-131). Mr. Loftus stated that, even in the case of extremely tardy claims, the company would sometimes "waiv[e] our right to deny [the] claims" (J.A. 131). But regardless whether respondent was so generous as to make payment in the face of such untimeliness, its recognition that payment in these circumstances was a waiver of its "right to deny" the claims is flatly inconsistent with its contention here that it was bound by an unconditional obligation to pay as soon as an employee received medical services.

ment was sought was a "pre-existing condition," or that the expenditures otherwise failed to qualify as a "covered medical expense." Although the Claims Court characterized the claims processing procedures as "ministerial" and "administrative" (Pet. App. 12a),[12] the court found that only 90% of the amounts claimed by respondent's employees, on average, were actually approved for payment (*id.* at 12a-13a). Because there thus existed a substantial possibility that any particular claim, once filed, would be denied in whole or in part, respondent's obligation to make payment to these individuals, like its liability to pay those who had not filed claims at all, was neither "uncon-

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[12] The record in fact refutes the Claims Court's statement that processing of claims was "ministerial." Many claims, of course, were paid by respondent without dispute, but the direct testimony of respondent's own witness gave examples of "gray areas" in which special processing and investigation by supervisors would be necessary in order for respondent to determine its view as to what the proper amount of reimbursement would be. See, *e.g.*, J.A. 134. Indeed, one of the principles of Prudential's "claim philosophy," which was put forth by respondent as illustrative of how its plan was administered, is that "[a]ny questionable claim will be thoroughly investigated and fully documented before a decision is made" (J.A. 177). Respondent's reliance (Br. in Opp. 6-7) on the fact that relatively few lawsuits were filed in connection with its health plans, as compared with the number of claims filed, is quite misplaced. Most health insurance claims involve relatively small sums that would not warrant the expense of litigation. The number of lawsuits gives no indication at all of how many of respondent's determinations were disputed by employees, successfully or unsuccessfully, at the administrative level. It is well settled, of course, that a liability can be "contested," and therefore contingent for accrual purposes, without the filing of a lawsuit. See Treas. Reg. § 1.461-2(b)(2); *Dixie Pine Co. v. Commissioner, supra.*

ditional" nor "absolute" at the close of the 1972 tax year.[13]

2. a. The Claims Court below held that respondent's liability "was not based on the filing of a claim" but rather became "fixed under the * * * self-insured plans upon occurrence of the insured event—the receipt of covered services by [respondent's employees]" (Pet. App. 15a). Respondent similarly contends that, "[o]nce the [medical] services were received," its obligation to pay reimbursement "was contingent no longer" because it "could not avoid liability" (Br. in Opp. 14). But this statement is simply incorrect. Even after an employee had received medical services, respondent would indisputably

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[13] If the employee's filing of a claim, rather than respondent's processing and approval of the claim, were held to be the "last event" necessary to fix respondent's obligation to pay reimbursement, there would still be no basis on the record in this case to allow respondent to deduct any portion of its IBNR reserve. In constructing that reserve, respondent made no reference to employees' actual receipt of medical services, or to employees' actual filing of claims, during 1972. Rather, respondent used statistics from prior years that showed the aggregate amount of claims typically paid and the average "lag time" between employees' receipt of services and the insurers' tender of reimbursement. Given this mode of construction, it would be no easy matter to "break down" respondent's 1972 year-end IBNR balance into two components, one reflecting its potential liability on claims not yet filed, the other reflecting its potential liability on claims filed but not yet processed. In any event, respondent had the burden of proving its entitlement to a deduction (*Helvering* v. *Taylor*, 293 U.S. 507, 514-515 (1935)), and, as we have noted above (page 6, *supra*), respondent introduced no evidence that would permit its IBNR balance to be broken down in this way. It does appear, however, that the bulk of the reserve represents potential liability on claims not filed, since respondents advises (Br. in Opp. 5) that most of its employees' claims are processed "expeditiously."

"avoid liability" if (1) the employee did not file a properly-documented claim for reimbursement or (2) respondent determined that a filed claim did not qualify for payment. An employee's visit to a doctor, like respondent's antecedent signing of the collective bargaining agreement, was a necessary but insufficient condition to create an obligation to pay on respondent's part. An employee's receipt of medical services undeniably fixed that employee's liability to pay the doctor for the services that he had received. But respondent's liability was not to pay the doctor, but rather to reimburse the employee. And respondent had no obligation to reimburse any employee until that individual had filed a claim and that claim had been approved.

The fact that the seminal event triggering the liability under the collective bargaining agreement can be said to have occurred in 1972, is, of course, irrelevant under the "all events" test, which turns on when the obligation to pay becomes fixed and certain. Until it has resolved the uncertainty about reimbursement by approving the claim for payment, respondent is in precisely the same position as the taxpayer in *Lucas* v. *American Code Co.*, *supra*, who tried to take a deduction for a contractual liability that arose in the taxable year, but did not become certain until the resolution of a lawsuit at some future time. Under the "all events" test, tax accounting must look to the time when an obligation to make payment becomes certain, not to the moment when the underlying obligation arises in a contractual sense. In this case, that obligation did not become certain until a claim for reimbursement was filed and was processed by respondent.[14]

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[14] Several lower court decisions also illustrate this basic principle that underlies the "all events" test. For example, in

b. Besides failing to reflect *fixed* obligations, the amounts comprising respondent's IBNR reserve do not reflect any *actual* obligations, fixed or otherwise.

Trinity Construction Co. v. *United States*, 424 F.2d 302 (5th Cir. 1970), the court held that an accrual-basis taxpayer could not take a current deduction for future life insurance premiums that it was already contractually obligated to pay on behalf of its employees. Because the payments would not actually be made if the employee died before the premium was due, the obligation was not sufficiently certain to justify accrual. See also *Bennett Paper Corp.* v. *Commissioner*, 699 F.2d 450 (8th Cir. 1983) (contractual obligation under profit-sharing plan to pay bonuses in future years); *World Airways, Inc.* v. *Commissioner*, 62 T.C. 786 (1974), aff'd, 564 F.2d 886 (9th Cir. 1977) (contractual obligation to make future payments for statutorily-required engine overhauls).

In seeking to justify its expansive reading of the "all events" test, the Claims Court relied in part (Pet. App. 13a) upon a line of Ninth Circuit cases culminating in *Kaiser Steel Corp.* v. *United States*, 717 F.2d 1304 (1983). In *Kaiser Steel*, the Ninth Circuit held that an employer's obligation to make workers' compensation payments became "fixed" once the worker had been injured and the employer had either been found to be liable or had determined not to contest its liability; the Claims Court concluded that *Kaiser Steel* stood for the proposition that "the fact of *injury* establishes the fact of *liability*" (Pet. App. 13a (emphasis in original)). We believe that *Kaiser Steel* is distinguishable from the instant case in several respects. In *Kaiser Steel*, the following critical events had occurred before the close of the tax year: the employee had in fact been injured; the employee had actually filed a claim for workers' compensation benefits; and the employer had conceded liability on that claim. In the present case, by contrast, respondent as of the close of the tax year had no way of knowing whether any employees had in fact received medical services; the employees in any event had not filed claims for benefits; and respondent reserved the right to deny each claim in whole or in part. Although we believe that *Kaiser Steel* is fairly distinguishable on these grounds, we are frank to admit that we believe that the case was wrongly

Respondent made no effort to ascertain whether any employee had in fact received medical services before the close of the 1972 tax year. Rather, respondent simply assumed, based on projections from past experience of Aetna and Prudential, that a substantial number of employees had received covered medical services during this period, and that their claims ultimately would lead to more than $5.5 million in payments. The amounts shown in the IBNR reserve thus represented nothing more than an educated guess as to aggregate liability. Although it was of course likely that *some* employees had gone to the doctor during the last quarter of 1972, respondent could not definitively state that a single employee had incurred a single penny in covered medical services during that time. Respondent thus seeks to take a $5.5 million deduction without being able to identify any actual obligations that are reflected in that amount.

This sort of aggregate estimate is incompetent as a matter of law to "establish the fact of the liability" (Treas. Reg. § 1.446-1(c)(1)(ii)). It is well settled that a liability becomes "fixed" only when it is based

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decided. Contrary to the Ninth Circuit's view, the employer's obligation to pay was still contingent on the extent of the injured worker's future medical treatment, the duration of his disability, and other variables that could not be known until after the close of the taxable year. We note that Congress in 1984 specifically overturned the result in *Kaiser Steel*, providing that workers' compensation payments cannot be deducted until "economic performance" occurs, that is, until "payments to [the injured worker] are made." I.R.C. § 461(h)(2)(C)(i); see note 9, *supra*. The discussion of this amendment in the legislative history, entitled "Premature Accruals," criticized the *Kaiser Steel* line of cases as allowing "overstated deductions." H.R. Rep. 98-432, 98th Cong., 2d Sess. Pt. II, at 1252-1255 (1984).

on known facts respecting individual claimants; an estimate suggested by past experience is insufficient to satisfy the "all events" test. Respondent here is in the same position as the taxpayer in *Brown* v. *Helvering*, *supra*, who was practically certain that he would have a significant future liability for return premiums because past experience suggested that some policies written during any given year would inevitably be cancelled later on. See 291 U.S. at 197-198, 201 n.7. But this Court held that the taxpayer could not deduct his estimate of that aggregate liability because "[i]n respect to no particular policy written within the year could it be known that it would be cancelled in a future year." *Id.* at 201.

This Court sounded the same theme in *American Automobile Ass'n*, *supra*, when it explained that aggregate statistical estimates, while satisfactory for financial accounting purposes, are unacceptable in tax accounting. When a company projects an expense on a statistical basis "without regard to * * * individual expense * * *, but consistently with overall experience, [its] accounting doubtless presents a rather accurate image of the total financial structure, but [it] fails to respect the criteria of annual tax accounting and may be rejected by the Commissioner." 367 U.S. at 692. In short, " 'the fact that the percentage of items which will be paid can be estimated with reasonable accuracy is not sufficient to support accruals. The individual items must represent fixed liabilities.' " *Union Pac. R.R.* v. *United States*, 524 F.2d 1343, 1351 (Ct. Cl. 1975), cert. denied, 429 U.S. 827 (1976) (quoting *Denver & Rio Grande Western R.R.* v. *Commissioner*, 38 T.C. 557, 572 (1962)).

c. The impermissibility of respondent's attempt to deduct a statistical estimate of its aggregate lia-

bility is well illustrated by the course of decisions in *Milwaukee & Suburban Transport Corp.* v. *Commissioner*, 18 T.C.M. (CCH) 1039 (1959), rev'd in part, 283 F.2d 279 (7th Cir. 1960), vacated and remanded, 367 U.S. 906, on remand, 293 F.2d 628 (1961). The facts there were quite similar to those here. The taxpayer created on its books a self-insurance reserve representing its year-end estimate of the probable amounts that it would have to pay in the future on claims arising out of accidents in which its equipment was involved during the taxable year (18 T.C.M. at 1049). Part of this reserve reflected anticipated liability on "potential claims" that had not been filed before the close of the tax year (*id.* at 1048, 1050). The balance reflected anticipated liability on claims that had been filed but on which the taxpayer either actively contested or "did not during [the taxable] year[] admit its liability" (*id.* at 1049-1050). The taxpayer conceded that it had no specific year-end liability to any individual claimant, but argued that, if the claims were "viewed in the aggregate, it [could] be taken as certain that [it would] have some liability and that estimates of its total net liability with respect to the aggregate of [the] claims" should be deductible (*id.* at 1050). The Tax Court, relying on this Court's decision in *Brown* v. *Helvering*, *supra*, rejected the taxpayer's argument, refusing to permit the taxpayer to deduct "a reserve for contingent liabilities in respect of unsettled and potential claims" (18 T.C.M. at 1050-1051 (citing 291 U.S. at 201)).

The Seventh Circuit reversed the Tax Court's judgment on this issue and held that the reserve was deductible (283 F.2d at 283-288). The court of appeals emphasized that "[t]he accidents out of which

the various claims gr[e]w undoubtedly ha[d] occurred" during the taxable year (283 F.2d at 286), and it held that this was sufficient to fix the taxpayer's liability under the "all events" test. "Because of the number of claims," the court reasoned, "it is apparent to everyone that there is going to be liability, and the only question is [o]n which particular claims this liability will occur. * * * If overall liability can be accurately predicted, there should not be any objection to the fact that it cannot be tied down securely [o]n any particular claim" (*id.* at 287).[15]

The Commissioner petitioned for certiorari. *Commissioner* v. *Milwaukee & Suburban Transport Corp.* (No. 843, 1960 Term). This Court granted the petition, vacated the Seventh Circuit's judgment, and remanded for reconsideration in light of *American Automobile Ass'n* v. *United States*, *supra*. See 367 U.S. 906 (1961) (citing 367 U.S. 687). On remand, the Seventh Circuit recalled its mandate, vacated its judgment, and affirmed the Tax Court "with reference to the accounting method issue." 293 F.2d 628 (1961). In so doing, the Seventh Circuit correctly concluded that the deduction of a self-insurance reserve representing a mere statistical estimate of aggregate liability is impermissible under the reasoning that this Court adopted in *American Automobile Ass'n*. That conclusion is equally applicable in the

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[15] In so holding, the Seventh Circuit relied heavily on a case that it viewed as "directly on point," *Ocean Accident & Guarantee Corp.* v. *Commissioner*, 47 F.2d 582 (2d Cir. 1931). But the court overlooked the crucial difference between *Ocean Accident* and the case before it, viz., that the former involved an insurance company, which Congress has specifically permitted to deduct reserves. See pages 21-29, *supra*.

instant case, and we believe that it dictates reversal of the Federal Circuit's judgment.

d. Respondent suggests (Br. in Opp. 6, 15, 20) that the lack of certainty in its IBNR reserve is not a theoretical problem, but only a practical difficulty that assertedly arises because it is a large corporation with many employees. "If a claims processor had been at the hospital on the day an employee was discharged," respondent says, "the processor could have processed and calculated the amount of the medical benefit at that time" (Br. in Opp. 6). Respondent points out that it "had approximately 56,000 employees in 1972" and that to have stationed claims processors at multiple locations around the country would have entailed an unreasonably burdensome expense (*id.* at 20). Because an employer with relatively few employees could accomplish this feat more inexpensively, and thus satisfy the "all events test" on our view of the law, respondent concludes that our position discriminates against large employers and thus produces an "irrational and unjustifiable" result (Br. in Opp. 20).

This contention is quite beside the point. Respondent of course is correct in asserting that (1) if it had stationed a claims processor at the doctor's office and (2) if the processor had given a claim form to the employee and (3) if the employee had filled out the form and submitted it to the processor and (4) if the processor had reviewed the claim and approved it for payment in full and (5) if all those events had occurred before December 31, 1972, then respondent would have been able to deduct its liability to reimburse that employee as a 1972 business expense. But that is only to say that respondent could have structured its medical plan in a way that would have

enabled it to pass, rather than doomed it to fail, the "all events" test. Obviously, whenever the timing of a deduction is at stake, a taxpayer may have at his disposal various steps that he might take to accelerate into the current tax year the "last event" necessary to fix his obligation, with the result that he would qualify for a current tax deduction. In deciding whether to take those steps, a cost-efficient taxpayer will compare the expense of doing so to the benefit he would gain, in terms of the time value of money, by getting his deduction this year rather than next. In the instant case, respondent decided not to station claims processors in doctors' offices around the country, and that decision was probably a rational economic judgment. But the consequence of that decision is that many claims for 1972 medical services were not filed by employees or approved by respondent until after the tax year closed, with the result that respondent failed the "all events" test and thus must defer its tax deduction until 1973 or later. A corporation that declines, for sensible business reasons, to undertake steps necessary to garner a current tax benefit cannot be heard to complain. As this Court put it in *Thor Power Tool Co.*, 439 U.S. at 545-546: "There is * * * no reason why [a taxpayer] should be entitled, for tax purposes, to have its cake and to eat it too."

e. The fact that respondent's IBNR reserve represented a mere statistical estimate of aggregate liability, rather than a set of specific and individualized obligations, highlights the sharp difference between this case and *United States* v. *Hughes Properties, Inc.*, *supra*. In *Hughes Properties*, the Court held that the taxpayer could accrue the amounts shown on the jackpot meters of its progressive slot machines at the

close of the taxable year. Nevada law created a statutory obligation for the taxpayer to maintain the amounts displayed on the meters and to pay them to the eventual winner. See slip op. 8. This Court held that this obligation was sufficiently "fixed and certain" to satisfy the "all events" test: "[a] part of the machine's intake was to be paid out, that amount was known, and only the exact time of payment and the identity of the winner remained for the future" (slip op. 10). In marked contrast to the situation in the instant case, the taxpayer's accountant in *Hughes Properties* could walk around its place of business at the close of the taxable year and point to the individual fixed obligations—emblazoned on the face of each progressive slot machine—that the taxpayer sought to deduct. Here, respondent cannot point to any specific and individual obligation at the close of the taxable year. It seeks, rather, to deduct an aggregate estimate of the liabilities that will become fixed in the future if and when individual employees file claims for reimbursement and those individual claims are approved for payment. Although Congress has chosen to permit insurance companies to deduct reserves computed in this way, Congress has not extended that benefit to ordinary accrual-basis taxpayers, and this Court's decisions confirm that the deduction respondent seeks for its IBNR reserve is impermissible.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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No. 85-1385

IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA,

Petitioner,

v.

GENERAL DYNAMICS CORPORATION, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

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QUESTION PRESENTED

Was the taxpayers' liability at the end of 1972 for employee medical benefits for medical services received by their employees in 1972 fixed and certain for the purposes of the "all events" test, as both the trial court and the appellate court held, and therefore deductible on the accrual basis in 1972?

PARTIES TO THE PROCEEDING

In addition to the party named in the caption, General Dynamics Land Systems, Inc. (formerly called Stromberg-Carlson Corporation), DatagraphiX, Inc., Material Service Corporation and Marblehead Lime Company are respondents. They are subsidiaries of General Dynamics Corporation.

STATEMENT REQUIRED BY RULE 28.1

Respondents have the following affiliated corporations, companies and partnerships: Mansour-G.D. Ltd.; Mines SNA, Inc./SNA Mines, Inc.; Etudes Techniques et Constructions Aerospatiales, S.A.; Tusas Aerospace Industries, Inc.; and Continental Cement Company. Respondents have no other parent corporation and no other subsidiary which is not wholly owned.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA,

Petitioner,

v.

GENERAL DYNAMICS CORPORATION, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

BRIEF FOR RESPONDENTS

STATEMENT OF THE CASE

The issue in this case is the proper timing for the deduction by these accrual-basis taxpayers of their liability for medical benefits received by their employees.

Since October 1972, taxpayers have directly provided regular medical benefits to their employees and their employees' dependents. (J.A. 18, 20, 81-83, 85.)* At the end

* References are as follows: "Pet. App." refers to the Appendix to the Petition for a Writ of Certiorari; "J.A." refers to the Joint Appendix; "PX" refers to Plaintiffs' Trial Exhibit; "Tr." refers

(Footnote continued on following page)

of 1972, the taxable year at issue, the taxpayers had not actually paid for all of the medical services received by their employees during 1972. This occurred because there is a lag in time between the receipt of medical services by the employee and the actual payment for those services by taxpayers. (J.A. 26.) At year-end, there were employee claims for 1972 benefits which had not yet been filed and other 1972 claims which had been filed and were being processed. (J.A. 26.) Because taxpayers were on the accrual basis, they accrued the expense for these unpaid 1972 medical benefits on their books. (J.A. 18, 27-28.)

These medical benefit expenses are ordinary and necessary business expenses of the type which are clearly deductible. (J.A. 19.) Thus, the issue is one of timing: must these expenses for medical services received by employees in 1972 be deducted in 1972 or must they be deducted in a later year. The proper timing for a deduction by accrual-basis taxpayers is governed by the "all events" test of Treasury Regulation § 1.461-1(a)(2). Under that test, a liability must be deducted in the year in which all events have occurred which determine the fact of liability.* Actual payment of an expense by year-end is not required. (J.A. 18.)

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footnote continued

to the trial transcript; "Pet." refers to the Petition for a Writ of Certiorari; "Pet. Br." refers to Petitioner's Brief on the merits. PX 1 through 10 and PX 13 through 46 were offered at Tr. 31-40 and received in evidence at Tr. 40-41. PX 47 was offered at Tr. 41-42 and received in evidence at Tr. 43.

* The "all events" test has a second element which must also be satisfied: the amount of the liability must be determinable with reasonable accuracy. Both lower courts in this case concluded that the second element (as well as the first) had been met. (Pet. App. 1a, 4a-5a, 16a-17a.) The government deliberately did not seek review of the "amount" issue. (Pet. 13 n.2; Pet. Br. 33 n.10.) Consequently, that issue is now foreclosed, and the government's direct and indirect discussion of the "amount" issue should be disregarded.

In determining whether the events establishing the fact of liability have occurred, it is necessary to focus on whether, immediately following the employee's receipt of medical services, the combination of then existing facts concerning (1) his employment status, (2) the nature of the medical services received and the amount charged for them, and (3) the provisions of the medical benefit plans and the standards used in processing claim forms rendered taxpayers' liability for those medical benefits definite and certain, rather than leaving it contingent or contested.

The Factual Record. Despite the fact that the government seeks, in effect, to have this Court set aside the trial court's findings of fact, which were affirmed by the Court of Appeals, it does not describe the evidence or attempt to demonstrate that the findings are "clearly erroneous." Instead, the government states its own general assumptions about the nature of medical benefits and then argues as though these assumptions were the facts adduced at trial.

However, there is a detailed factual record in this case. In addition to a stipulation as to many matters (J.A. 17-38), taxpayers presented a substantial number of exhibits and the testimony of five witnesses. Three of the witnesses testified specifically about the facts relevant to the issue now before this Court. Those three witnesses were: James A. Hawkins, the Director of Employee Benefits from 1970 to 1980, who was in charge of taxpayers' medical benefit programs, including the design and administration of the plans (J.A. 81-83); J. David Loftus, an administrator in the Group Claim Department of The Aetna Life Insurance Company ("Aetna"), who had 23 years of extensive experience in claims processing and group medical benefit plan administration (J.A. 100-103); and C. Robert Schaal, manager and senior claim consultant of the Group Health Claim Administration Division of The Prudential Insurance

Company of America ("Prudential"), who had 23 years of extensive experience in claims processing and administration of medical benefit plans in general and the taxpayers' plans in particular (J.A. 142-145).* The complete testimony of these three witnesses is contained in the Joint Appendix (J.A. 81-176). The government offered no witnesses, but introduced some documents relating to the plans.

The examination of these three witnesses and the content of many of the exhibits focused precisely on the nature and provisions of the taxpayers' medical benefit plans and the standards and procedures by which they were administered. This evidence provided a specific factual basis for determining whether claims processing was ministerial and uncontested (as taxpayers assert), or uncertain, discretionary and contested (as the government suggests). After hearing the evidence, the trial court found that taxpayers' liability attached upon the receipt of medical services by their employees and did not await the completion of the routine and clerical processing of the claim forms for payment. (Pet. App. 11a-13a, 15a.)

The Medical Benefit Plans. The evidence showed that the plans provided basic medical benefits and major medical benefits. (J.A. 21, 82-83, 105-106, 145-146.) The basic medical benefits included hospital costs (primarily room and board charges), doctors' fees for surgery, costs for anesthesia and other medical services. The basic plan paid 100% of covered items up to specified and pre-established limits (*e.g.*, $60 per day for a hospital room; $200 for an

* Aetna and Prudential have administered the plans ever since taxpayers took over direct liability for the medical benefits in 1972. (J.A. 20-21; PX 4; PX 5.)

appendectomy) without a deductible.* (J.A. 48-52, 63-77, 83, 105.) The major medical benefits provided for costs exceeding those covered by the basic medical plan, as well as certain additional items (*e.g.*, prescription drugs). The major medical plan had an annual deductible (typically $100) and then paid for costs on a shared basis (typically, taxpayers paid 80% and the employees, 20%). (J.A. 52-54, 64-65, 106.) Each plan described in detail the persons covered and the exact nature and extent of the benefits provided. (J.A. 21, 48-77; PX 40; PX 5, pp. 13-217.)**

Taxpayers provided these medical benefits to their employees as part of the consideration for the employees' services. (J.A. 18.) Taxpayers promised their employees that the benefits provided by the plans would be paid. (J.A. 19.) Booklets describing the plans were distributed to all of the employees so the employees were fully informed of the benefits to which they were entitled. (J.A. 22, 48-77, 85-86; PX 40.) Taxpayers' liability for the medical benefits was a matter of contract; liability did not depend upon any determination that the need for the benefits resulted from anyone's fault or wrongdoing. (J.A. 25.)

Under the plans, taxpayers' general contractual liability to provide benefits became fixed as to particular medical expenses of a specific employee at the time the medical services were received by that individual. (J.A. 87.) At

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* For example, the plan described in Plaintiffs' Exhibit 9 (J.A. 48-77) states that the basic medical plan will pay actual hospital room and board expenses up to a maximum rate of $60 per day for 365 days. (J.A. 63.) It states that other hospital costs (such as an operating room charge) will be paid up to a total of $800. (J.A. 48, 63.) The plan has an extensive schedule of the amounts it will pay for specific surgical procedures. (J.A. 66-76.)

** One plan, Plaintiffs' Exhibit 9, is set forth in the Joint Appendix (pages 48-77); another is Plaintiffs' Exhibit 40. Both plans are typical of taxpayers' medical benefit plans. (J.A. 22.)

that time, all conditions to the liability had occurred and been satisfied: (1) the person receiving the services was covered under the plan, (2) the services were covered under the plan, and (3) the services had been performed. At that time, the employee had a vested right to payment of his benefits according to the amounts specified in the plan.

All witnesses testifying on the subject agreed that under the provisions of taxpayers' plans, the critical time for fixing the liability for specific benefits was when the services were received, not when claims for payment were filed and/or processed. Once services had been received while the plan was in effect, taxpayers could not avoid liability for those services by terminating the plans prior to the filing or complete processing of a claim. (J.A. 87-88, 133-34.) Similarly, termination of an employee's employment would not extinguish taxpayers' liability for services received prior to such termination of employment, even if the claim form was filed afterwards. (J.A. 87, 133, 172-173.)

Processing of Claim Forms. To obtain payment for medical services received, employees submitted claim forms, which underwent a routine, standardized processing procedure and were paid according to the benefit schedules contained in the plans. (J.A. 23, 88-89, 106-110, 149-154.) In filing claim forms, employees submitted the raw data, such as doctor's and hospital bills. (J.A. 23; PX 10.) The amount of reimbursement to which employees were entitled under the plans was calculated by claims processors. (J.A. 23-24, 89.)

A simple clerical check was made to verify that the person receiving services was covered (that is, that he was employed and had satisfied any applicable waiting period if he was a new employee) at the time of treatment. (J.A.

23, 89-90, 149-50.) The forms were then processed by matching the claim data against the plan provisions to calculate and pay the amounts due. (J.A. 23-24, 88-89, 107-110, 150-152.) The benefit calculations were made by experienced claim processors who were familiar with taxpayers' plans. (J.A. 23-25, 107-108, 148-149.) They followed the very detailed provisions and schedules of the plans, which were augmented by guidelines and routine procedures established by Aetna and Prudential.* (J.A. 25, 108-109, 112-116, 152-153, 157, 160.) The processors excluded amounts which were not covered at all (such as a hospital meal for a patient's guest and television rental charges on hospital bills), calculated the basic medical benefits, and then calculated the major medical benefits.** (J.A. 107-110, 151-154.) Approximately 95% of the claims were handled by the regular processors and only 5% required consideration by more experienced supervisors—still in a routine manner. (J.A. 111-112, 154-155.)

The government seems to suggest (Pet. Br. 3) that application of plan provisions to situations which happen to involve preexisting conditions, prevailing rates, work-related conditions, and services not reasonable and customary is difficult and problematical. However, Messrs. Loftus and Schaal described in detail how these matters were handled in a routine fashion. Briefly, the evidence on these matters was as follows:

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* Aetna's claims processors typically were women, twenty years of age, high school graduates with one year of college or business experience. (J.A. 104-105.)

** In most instances, all necessary data was contained in the papers when the processors received them. In those instances where additional data was necessary, rather than reject the claim, the missing data was obtained, usually by telephone or letter to the employee, doctor or hospital, as the case might be. (J.A. 23, 121, 163-164.) Then the processing would be completed.

Preexisting conditions applied only to new employees and only to certain types of their claims (*e.g.*, chronic conditions like gall bladder problems). Taxpayers' plans paid medical benefits for preexisting conditions unless the employee had received medical treatment for the particular condition within ninety days prior to the effective date of coverage. In the small number of claims involving new employees where the claim suggested a preexisting condition, the necessary information was on the claim form or was collected by a routine telephone call or letter. The information easily established whether the condition was treated in the ninety-day period. If not, payment was made. (J.A. 128-130, 162-163.)

As to excessive charges for services, Prudential and Aetna maintained surgical profiles or printouts showing the levels of charges being made by physicians in a locality for a particular surgical procedure. Prudential paid physicians' bills that fell in the 90th percentile category of charges for that particular procedure (*i.e.*, 90% of the bills of local physicians fell at or under that level). Aetna paid these at or below the 85th percentile. Processors merely had to compare the amount of the bill with the appropriate percentile line on the printout. Before refusing to pay part of a physician's bill which exceeded the applicable percentile, a call was made to ascertain whether complications not disclosed on the claim form justified the higher charge. (J.A. 113-116, 160-161.)

The claim form and taxpayers' records reporting injuries on the job showed whether the claim resulted from a work-related injury or illness covered by workmen's compensation. Consequently, these claims were sorted out on a routine basis. (J.A. 98-99, 170-171.)

Claims processors were supplied with detailed lists of types of covered and non-covered services and expenses and guidelines for expected durations of hospital confine-

ment for particular surgical procedures. Generally, these lists immediately established which services and expenses were covered and which were not. If the length of the hospital stay exceeded these routine guidelines, the employee's physician was contacted to ascertain whether there had been medical complications not shown on the claim form. (J.A. 25, 108-109, 112-116, 119-121, 152-154, 157, 160.)

Once claims were processed, checks were prepared and issued for the payment of the benefits which were due. An explanation sheet was sent to each employee explaining the calculation of the benefit amount and which items were not covered by the plan and thus not paid. (J.A. 25, 89, 109-110, 134, 151-152.)

Nonexistence of Disputes. Disputes regarding medical benefit payments were virtually nonexistent. (J.A. 25-26, 90-91.) By their very terms, the plans did not purport to pay 100% of all medical costs: the basic medical plan provided for specific amounts and the major medical plan shared the costs on an 80/20 basis after applying a specific deductible. (J.A. 83-84, 169-170; see J.A. 48-77 and PX 40.) Employees did not themselves calculate the amount due; instead, they submitted all their medical bills, and the processors made the calculations. (PX 10; J.A. 23-24.) Consequently, nonpayment of items not covered by the plans did not reflect the "denial of claims" and did not cause disputes. Experience shows that in the aggregate, 90% of total medical costs were covered by the plans and thus paid. The 10% of total medical costs which were, on the average, not covered by the plans were, of course, not paid.* (J.A. 91.) In effect, 100% of covered costs were paid.

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* Most of the 10% of non-paid costs derive from the fact that the major medical plans generally call for the employer to pay 80% of the excess over the basic medical payment plus a deductible. (J.A. 52, 64, 92.)

Furthermore, the philosophy applied in processing the claims under the plans was to pay everything which was due. Taxpayers were interested in promoting good employer-employee relations, not in causing discord and disaffection. (J.A. 92-93, 123, 173.) Mr. Hawkins, taxpayers' Director of Employee Benefits, testified that he could recall no lawsuits regarding medical benefits in the 10-year period from 1970 to 1980. (J.A. 91.) This was supported by Mr. Schaal of Prudential, who testified that he could recall only two lawsuits regarding taxpayers' medical benefit plans in the period from 1969 to 1983.* (J.A. 171-172.)

Background of this Litigation. At year-end 1972, taxpayers determined the amount of their liability for unpaid medical services which had been rendered in 1972. (J.A. 18, 26-32.) This amount was accrued as a liability on their books. (J.A. 18, 26-32.) It did not include any provision for medical costs not covered by the plans, disputed claims, or medical services to be rendered in later years. (Tr. 146-147, 228-229.) The majority of the unsubmitted claims for 1972 medical services were submitted in the first few months of 1973. (J.A. 93.) Of the $4,583,893 paid in 1973 and 1974 for medical services received in 1972, all but $80,279 was paid in 1973. (J.A. 35.)

After considering the evidence, the Claims Court rejected the government's view that, under the "all events" test. taxpayers' liability was not fixed until claims had

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* This absence of disputes concerning the taxpayers' medical benefit plans was corroborated by the insurance companies' own general experience. Aetna had only 129 lawsuits in 1979 when it made over 16,000,000 medical benefit payments and only 199 lawsuits in 1982 when it made over 33,000,000 payments. (J.A. 134-135.) Prudential had 96 lawsuits in 1982 in relation to 450,000,000 medical benefit payments. (J.A. 172.)

been filed and processed. Instead, based on substantial evidence regarding the plans and how processing actually operated, the Claims Court found that the processing was routine, clerical and ministerial, and that taxpayers' liability was sufficiently fixed and certain so as to satisfy the "all events" test. (Pet. App. 7a, 11a-15a, 17a-18a.) The Court of Appeals for the Federal Circuit affirmed. (Pet. App. 1a, 5a.)

SUMMARY OF ARGUMENT

Since 1926, the standard for determining when an accrual-basis taxpayer's expense is to be regarded as "incurred" for federal income tax purposes has been the "all events" test. *United States* v. *Hughes Properties, Inc.*, ____ U.S. ____, 106 S.Ct. 2092, 2096 (1986); *United States* v. *Anderson*, 269 U.S. 422, 440-41 (1926); Treasury Reg. § 1.461-1(a)(2). The sole issue before this Court is whether the lower courts were correct in concluding that taxpayers' deduction for accrued medical benefit expenses satisfied the first prong of the "all events" test, *i.e.*, that by year-end 1972, all events had occurred which established the fact of liability.

The government addresses the merits of this critical issue beginning at page 30 of its brief. The preceding portion of the government's brief is devoted to irrelevant arguments and contentions that expense deductions by accrual-basis taxpayers should be viewed with skepticism. However, this Court and the lower federal courts have taken a much more realistic view. In cases in which the taxpayer's liability was contested or was contingent upon the occurrence of future events, this Court has denied the attempted deduction. On the other hand, when the facts

demonstrated the existence of a present, fixed liability, this Court has upheld the deduction notwithstanding efforts by the government to conjure up hypothetical circumstances in which payment of the obligation conceivably might not occur.

Confronting the issue in this case evenhandedly and with due regard to the findings of the Claims Court which were affirmed by the Court of Appeals, the outcome is clear. The uncontradicted evidence established that taxpayers' liabilities at the end of 1972 for medical benefits to employees who had received medical services but had not yet been paid were definite and certain, rather than contested or contingent.

The government ignores or glosses over both the uncontroverted trial evidence and the trial court's findings of fact; but this is clearly improper. The evidence established the extremely specific terms of the medical benefit plans with respect to how much would be paid for specific types of hospital confinements and particular medical and surgical procedures. Experienced claim handlers testified to the standard and routine procedures by which claims forms were processed—in effect, matching up the employees' expenses with the detailed provisions of the medical benefit plans. Virtually all of the claims were processed by clerical employees on a volume basis in accordance with routine procedures. Only a very small number of claims raised problems, and contests regarding medical benefit claims were virtually nonexistent. Consequently, once the employee had received specific medical services, the taxpayers' liability to that employee matured and became fixed according to the detailed provisions of the plans. After rendition of these medical services, neither termination of employment nor termination of a medical benefit plan could defeat taxpayers' existing liability to that employee.

The government argues that liability is not fixed until claim forms are filed and processed. The evidence and the findings of the trial court contradict the government's factual argument, and it is equally baseless as a matter of law. There is no evidence that any significant number of employees failed to file claim forms. In any event, failure to file a form is merely the equivalent of a waiver of an already vested right to payment. In the case of any fixed, accrued liability, the creditor or obligee may waive payment when the time comes. Therefore, acceptance of the government's argument that the possibility of waiver prevents fixation of liability would prevent the deduction of any unpaid expense. That is not the law.

As to processing, the evidence demonstrates that because of the detailed nature of the medical benefit plans and the processing routines, processing of claim forms is a routine, ministerial exercise of matching employee bills against benefit provisions. The cases, including *United States* v. *Anderson, supra*, the seminal "all events" test case, establish that the necessity for the processing of routine paperwork does not delay fixation of liability for purposes of the "all events" test.

The government asserts that liability is not fixed because at year-end taxpayers do not know the names of many of the employees who have received medical services and estimated the amount of their liability on an "aggregate" basis. However, this does not alter the fact that taxpayers had by year-end 1972 incurred liability in specific amounts to particular individuals who had, in fact, received actual medical services. In an analogous situation, this Court recently rejected the government's argument that lack of identification of a winning slot machine player prevented fixation of liability for progressive jackpots. *United States* v. *Hughes Properties, Inc.*, 106 S.Ct. at 2097. Furthermore, the government's objection to a so-

called "aggregate" method of calculation is relevant, if at all, to satisfaction of the second prong of the "all events" test, that the amount of the liability must be determinable with reasonable accuracy. But that issue is foreclosed because the government deliberately chose not to present it for review in this Court, correctly characterizing it as a purely factual question not warranting review. (Pet. 13 n.2; Pet. Br. 33 n.10.)

The bulk of the government's argument is made up of distractions and red herrings about reserves, financial accounting and insurance companies. Reserves can be created for any unpaid liability ranging from the most contingent and hypothetical to the most fixed and definite. Consequently, the presence or absence of a reserve is irrelevant, and the method by which it is calculated concerns only the "reasonable accuracy" prong of the test. There is no evidence in the record concerning financial accounting, and taxpayers have never sought to justify their deduction on the basis of financial accounting. Thus, the accounting argument is also irrelevant. Finally, taxpayers have never asserted that they are insurance companies, nor have they sought to justify their deduction by using the special tax provisions relating to insurance companies. Taxpayers who satisfy the "all events" test are entitled to a deduction, regardless of whether or not insurance companies could take deductions in similar circumstances.

The trial evidence, the findings of the lower courts and existing law establish that taxpayers have satisfied the "all events" test and that the lower courts' decisions should be affirmed.

ARGUMENT

I. THE "ALL EVENTS" TEST IS SATISFIED BY THE RECEIPT OF MEDICAL SERVICES BY EMPLOYEES IN 1972.

The first part of the "all events" test is that all events must have occurred which determine the fact of liability. Treasury Reg. § 1.461-1(a)(2). Under this test, a deduction is allowed when a liability is fixed and certain, *United States* v. *Anderson*, 269 U.S. at 440-41; *United States* v. *Hughes Properties, Inc.*, 106 S.Ct. at 2096; and denied when liability is either contingent or contested by the taxpayer, *Brown* v. *Helvering*, 291 U.S. 193, 200 (1934); *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516, 519 (1944).

The "all events" test has been interpreted in a practical manner: when the facts establishing liability have occurred, a deduction is proper even though technical procedures or paperwork required for payment have not yet been completed. *United States* v. *Anderson*, *supra*. As discussed below, the courts have repeatedly rejected the government's arguments that liability is not fixed until the time has come for payment of the obligation. To do otherwise would be to reject the accrual method of accounting and put everyone on the cash basis. The most recent rejection of the government's argument by this Court was last term in the *Hughes Properties* case, *supra*.

A. The Trial Court's Findings Of Fact Control This Case.

At the outset, it must be noted that the government improperly attempts to avoid the findings of fact and evidence in this case. It largely ignores the evidence and relies on its conjectures regarding medical benefits. But

taxpayers developed an extensive factual record regarding the medical benefit plans and claims processing, and based on evidence which withstood cross-examination, the trial court found for taxpayers. Thus, the government's suggestions and conjectures that claims processing is difficult and problematical, that people do not file claims, and that claims are contested must be rejected. The evidence and the findings are to the contrary: claims processing is clerical and ministerial (Pet. App. 11a-12a), claims are not contested (Pet. App. 12a-13a), and there is no evidence that any substantial number of people do not file claims. The evidence adduced by taxpayers and the findings of the trial court regarding the medical benefits plans and how they actually worked must be accepted. They are not clearly erroneous (indeed, the government does not attempt to show they are), and therefore are not subject to review by this Court. See *Berenyi* v. *District Director, Immigration and Naturalization Service*, 385 U.S. 630, 635-36 (1967); *Anderson* v. *Bessemer City*, 470 U.S. 564 (1985).

B. Liability Was Fixed When The Medical Services Were Received.

Taxpayers clearly satisfy the first part of the "all events" test: the liability for medical services which had been received was fixed and definite at the end of 1972, and was not contingent. The medical benefit plans were in existence and were quite specific regarding who was covered, what was covered, and what would be paid. Taxpayers had contractually obligated themselves to pay for the covered medical services received by covered employees. While prior to receipt of medical services, the plans merely represented potential or contingent liabilities for taxpayers to their employees at large, when the employee received actual medical services, the event which established taxpayers' specific liability to that specific

employee occurred. At that time, the employee was or was not covered by the plan; the medical services were received; and the plan specified the type and amount of benefits. Taxpayers' liability for those services had ripened; that liability was contingent no longer. The situation is like that of a simple contract. If A offers to pay B $500 provided B moves to Pittsburgh, the offer becomes irrevocable and B becomes entitled to the $500 as soon as he moves to Pittsburgh, even though he does not notify A at the time of the move.

The critical nature of the time at which medical services were received is demonstrated by several facts. Once services were received, subsequent termination of the plans would not terminate liability for the prior medical services. If an employee's employment ceased, taxpayers still had to pay for medical services received prior thereto. Once services were received, taxpayers could not choose to reduce the level of benefits and pay less than the amounts provided in the plans. Liability existed regardless of whether the claim form had been filed and/or processed before plan termination or termination of employment.

Thus, as the trial court properly held, once the medical services were received, the underlying liability was fixed; the fact of liability was established. (Pet. App. 11a-15a.)

C. Speculation That Some Employees Might Not File Claim Forms Does Not Make The Liability Contingent.

The government places great emphasis upon the fact that many of the employees who received medical services in late 1972 had not yet filed claim forms by the end of the year. The government speculates that some employees might never file claim forms through inadvertence, or because the amount is too small to bother with,

or conceivably because they might wish to conceal the nature of an illness from their employer.

First of all, the notion that some significant number of employees might fail to file claim forms to collect their medical benefits is, like most of the government's "factual" arguments, pure conjecture. There was no evidence that employees in fact failed to file claim forms. The evidence showed that each employee was given a booklet describing the medical plans so employees knew they were entitled to these benefits. (J.A. 22, 48-77.) Filing claims was not difficult; the employee presented raw data and did not have to calculate the amount covered by the plan. (PX 10.) Mr. Schaal testified that he did not understand why an employee would not file a claim, particularly since he would be dunned to pay the medical bills. (J.A. 176.) Hospitals generally sent their bills directly to taxpayers, who would inquire of the employee if a claim form covering that hospitalization was not turned in. (J.A. 150, 175.) It is exceedingly unlikely that employees would forego payment of items of significant amount.

Even assuming *arguendo* that some few employees do not claim their benefits, this would not negate the earlier existence of a fixed and definite obligation. Analytically, the failure of an employee to file a claim form amounts to a waiver of an already accrued right to benefits. Any obligee may decline or waive payment of any obligation, no matter how fixed or certain. The possibility of such waiver does not mean that the obligation never existed or was not fixed or certain. Otherwise, no accrued expense could ever be deducted because the possibility of waiver by the obligee would always exist at any time prior to payment.

A few examples will illustrate the point. An employee completes a week's work and has earned his pay for that

week. There is a possibility that he may fail to pick up his paycheck or take the check, misplace it and never cash it. Does that mean that there was no fixed obligation to pay his wages? Of course not. An employee who has spent three days in the hospital and is covered by a medical benefit plan authorizing $60 per day in benefits for the hospital room is no less definitely entitled to that money than he is to his pay for his last week's work. Alternatively, look at an example from the argument of the *Hughes Property* case. There the government agreed that if a painter painted a taxpayer's house for an agreed amount which was not paid by year-end, and in the following year the painter vanished and never got paid, the taxpayer would still have a deduction in the year the house was painted.* (No. 85-554, Transcript of Oral Argument 23-24.) Obviously, before the time of actual payment, any creditor might go out of business leaving no forwarding address, forgive the debt, or take the check and never cash it, but none of these events would negate the existence at the end of the previous year of a fixed and definite obligation to pay. In short, the possibility that the obligee may not accept payment is always present and does not defeat the deduction.

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* QUESTION: [From The Court] ". . . let's assume a taxpayer who agreed at the end of the year that it owed me $1,000, and then assume further, I just disappeared somewhere and he never had a chance to pay me.

Would that liability have accrued?. . . ."

MR. LAUBER: "It would be proper to accrue the liability, and if you vanished and he never had to pay it, he would then have income in later years. . . . For example, if somebody performed work for you and you agreed to pay that, the painter or the plumber, and you didn't pay them during the year but you are obligated to them, you are an accrual basis taxpayer. Even if the plumber vanished and never got paid, you would get a deduction for a proper accrual in the year you incurred the obligation to pay him." (Transcript 23-24.)

A variation of the government's waiver argument was rejected by this Court in *Hughes Properties*, 106 S.Ct. at 2099:

> There is always a possibility, of course, that a casino may go out of business, or surrender or lose its license, or go into bankruptcy, with the result that the amounts shown on the jackpot indicators would never be won by playing patrons. But this potential nonpayment of an incurred liability exists for every business that uses an accrual method, and it does not prevent accrual. [Citation omitted.] "The existence of an absolute liability is necessary; absolute certainty that it will be discharged by payment is not." *Helvering* v. *Russian Finance & Constr. Corp.*, 77 F.2d 324, 327 (CA2 1935).

Accord, Kaiser Steel Corp. v. *United States*, 717 F.2d 1304, 1306, 1307 (9th Cir. 1983); *Harrold* v. *Commissioner*, 192 F.2d 1002, 1004 (4th Cir. 1951).

As the Tax Court stated in *Buckeye International, Inc.* v. *Commissioner*, 49 T.C.M. 376, 382-383 (1984):

> The Regulation does not require that the taxpayer prove the impossibility of the occurrence of subsequent events that might extinguish or reduce in amount an existing liability. . . . Anytime a debtor incurs liability to make payments in the future, actual payment will be subject to analogous contingencies. Payment can never be certain until actually made. Respondent's interpretation of the regulation thus would virtually eliminate the accrual method of tax accounting.
>
> Respondent's regulation provides a two-part test and clearly distinguishes between the fact of liability and payment on the liability. As long as the liability exists in the year of accrual, uncertainty as to the amount of ultimate payment is irrelevant for purposes of the first requirement of the all events test.

The courts below properly rejected the government's waiver argument.

D. Ministerial Processing Of Claims Did Not Make Taxpayers' Liability Contingent.

While it is true that claims were not paid until processed, this does not mean that taxpayers were not liable for the purposes of the "all events" test until processing was completed. Liability under the plans was contractual (J.A. 25) and complete upon receipt of medical services. Liability was not based in any way whatsoever upon a determination of fault or wrongdoing by taxpayers. (J.A. 25.) No adversary was seeking to impose an unwanted liability on taxpayers. Instead, claims processing was merely a mechanism to calculate the exact amount of a liability taxpayers had already agreed in advance to pay. Claims were processed by the thousands in a routine, repetitive, systematized, clerical procedure. Based on the evidence presented at trial, the trial court correctly concluded that "defendant's emphasis on the claims-processing procedure is misplaced." (Pet. App. 11a.)

While claims processing served a verification function and was the mechanism by which the dollar amounts of the benefit calculations were made, the processing was not a set of "future events" which substantively determined the fact of liability. All of the facts upon which the processors based their calculations had already occurred before the process began and the calculations were not discretionary. The doctor or hospital had been visited, and the services for which payment was due had been performed. The plan of benefits was in effect, so the processor merely had to match the charges submitted against the plans' benefit schedules. Indeed, if the processor were physically at the doctor's office or hospital when the patient left, the calculation of the benefit payment could

have been routinely made on the spot.* Because processing was merely clerical, it by itself was not an event that had to occur for the "all events" test to be met.

A few illustrations will clarify the principles. If a medical benefit plan simply provided that an employee would get $50 for each visit to the doctor and $100 for each day spent in the hospital, it would be obvious to all that the employer's obligation was fixed when the employee went to the doctor or spent a day in the hospital. No one would seriously claim that the obligation was not fixed and definite until a claims processor went over the claim form to add up the number of days in the hospital or check to be sure that the file contained a written confirmation from the doctor of the employee's visit to his office.

Of course, the provisions of the taxpayer's medical benefits plans are more complicated. However, if (as the evidence shows) the provisions are sufficiently specific and detailed so that the benefits can be readily calculated in a routine manner, then the obligation is as definite and fixed as in the simple "$50 per visit to the doctor" example.

Thus, for example, if an employee stays in a semiprivate room in a hospital for three days at a charge of $70 per day and is covered by a medical benefit plan which pays semiprivate room rates up to a maximum of $60 per day, he is, on his discharge, entitled to medical benefits of $180. The claim could be processed routinely in a few minutes. If it were submitted to several different processors, they would reach the same result. Given the terms of the plans,

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* The point of this illustration is that the processing is so routine that a processor could do it on the spot in a few minutes. Hence, the government's argument (Pet. Br. 45-46) that the processor is not actually there misses the point.

the employee's submission of his total hospital bill for $210 (the only bill in his possession) does not amount to a "claim" for $210, and therefore, there is no denial of a "claim" for the additional $30. Under the plan the employee was never entitled to more than $60 a day and, if he had read the plan, he would know it.

Similarly, suppose an employee has an appendectomy operation and the operating physician charges $500. The employee is covered by a basic medical plan which states that it will pay up to $250 for an appendectomy, and a major medical plan, which states that it will pay 80% of the excess over $250 and that the employee will pay the remaining 20%. In this case, immediately following the operation, the taxpayer has a fixed obligation to pay the employee $450 ($250 under the basic plan plus 80% of the remaining $250 of the doctor's bill under the major medical plan). Again, of course, the employee will submit the only bill he has—the doctor's statement for $500. However, in view of the fact that the medical benefit plan clearly provides for payment of $250 plus 80% of the excess over $250, an employee who is familiar with the plan does not expect the entire $500 to be paid, nor will he contest the fact that he has to pay the 20% which is his responsibility under the plan. Again, there is nothing discretionary or problematical about the calculation. If it were submitted to several different processors, each would routinely come up with the same amount. Furthermore, the result does not change depending on the date of submission or processing of the claim.

The government lists four types of situations which it perceives as rendering the liability contingent until processing is completed. As the evidence summarized at pp. 6-9, *supra*, demonstrates, processing is done on a routine basis even in the cases in which these situations are present. Thus, clerical claims processors routinely sort out work-

related injuries, determine if a new employee was treated for a preexisting condition within 90 days before coverage commenced, check the length of a hospital stay to see if it matches their written guidelines or check the size of a physician's bill against their printout to see if it is within the 90th percentile of local charges. Three witnesses testified about these and other aspects of claims processing, and their testimony led the trial court to find that processing was "routine and clerical" and "ministerial in nature." (Pet. App. 12a.)

Given the true nature of claims processing under taxpayers' plans, the Treasury Regulation and relevant cases clearly establish that taxpayers' liability for medical services received in 1972 was fixed by the end of 1972 and that the filing and processing of claims did not change that result. The seminal case articulating the "all events" test, *United States* v. *Anderson*, *supra*, squarely supports taxpayers' position. *Anderson* involved the timing of a deduction for a munitions tax. The tax was based on munitions sold in 1916, but was not assessed, due or payable until 1917. The taxpayer deducted the tax in 1917, but the government asserted that the tax liability accrued before assessment and was deductible in 1916. This Court ruled in favor of the government, stating (269 U.S. at 440-41):

> Only a word need be said with reference to the contention that the tax upon munitions manufactured and sold in 1916 did not accrue until 1917. In a technical legal sense it may be argued that a tax does not accrue until it has been assessed and becomes due; but it is also true that in advance of the assessment of a tax, all the events may occur which fix the amount of the tax and determine the liability of the taxpayer to pay it. . . In the economic and bookkeeping sense with which the statute and Treasury decision were concerned, the taxes had accrued.

The decision in *Anderson* squarely supports taxpayers' deduction in 1972 because here the event which determines the fact of liability was the receipt of medical services. Since *Anderson* found that a step as important as assessment of the tax did not defer the deduction, here the filing and processing of the claim is not necessary to satisfy the "all events" test. Taxpayers' liability for medical expenses is deductible because substantively and practically it has accrued even though payment is not yet due. Relying upon *Anderson*, the trial court correctly held that claims processing was the type of "administrative" or "ministerial" step which does not delay the fixing of liability under the "all events" test. (Pet. App. 12a.)

The decisions below are also consistent with this Court's decision in *Continental Tie & Lumber Co.* v. *United States*, 286 U.S. 290, 295-98 (1932). There an accrual was held to be required currently for an award which had not yet been made and would be made in the future by the Interstate Commerce Commission pursuant to a newly enacted statute. Clearly, claim processing, involving calculations and evaluation, still had to occur before an award was ultimately made. Yet this Court concluded that the Commission's function was ministerial and thus did not preclude accrual.

This Court's decision last term in the *Hughes Properties* case, *supra*, is further support for the taxpayers' deduction. *Hughes Properties* involved the deductibility of the liability for progressive jackpots which were on casino slot machines at year-end. The government opposed deduction on the ground that the progressive jackpots had not yet been won, and it was completely uncertain when in the future they would be won, and by whom. The taxpayer asserted that for all practical purposes the liability was fixed since the state gaming rules precluded taxpayer from reducing the jackpots, and except in remote cir-

cumstances (*e.g.*, going out of business and bankruptcy), the taxpayer would have to pay the jackpot to someone at some time. Relying among other things on *Anderson*, this Court held the liability was fixed for purposes of the "all events" test. It rejected the "speculative possibility" that the jackpots might never be won. The winning pull by the lucky patron was not regarded by this Court as a necessary event to fix the liability at year-end; the last play on the machine fixing the jackpot amount at year-end was sufficient.

The decision in *Hughes Properties* clearly supports taxpayers' deduction in 1972. The receipt of medical services by employees in 1972 fixed taxpayers' liability to them just like the last pull on the slot machine. Since *Hughes Properties* found that the nonoccurrence of a step as important as the winning play on the machine did not preclude deduction, the failure to file claims and/or complete ministerial processing of benefit calculations by year-end should not defeat a deduction in this case. Indeed, the instant case is an even clearer case for the taxpayer. Here, the "winners" of medical benefits existed at year-end. Some had just not stepped up to the window for payment, but when they did, they would have to be paid their contractual benefits. Others had stepped up and would soon be paid.

Other recent cases demonstrate that liability may be fixed for the "all events" test even though payment depends upon events much more significant than the filing of claims and processing of paperwork. One such group of cases involves workmen's compensation liability where state statutes impose no-fault liability for occupational injuries to employees. The workmen's compensation statutes have detailed provisions regarding benefits for medical treatment, lost wages and permanent disability payments. There the issue has been the deductibility of self-

insurance reserves which included amounts for medical services to be rendered in future years and wages which would be lost in future years. Courts in those cases have found that the taxpayer's liability became fixed for the "all events" test at the time the employee was injured and *before* rendition of medical services. Deductions for the reserves were allowed even though they provided for future medical services and future lost wages. *Crescent Wharf & Warehouse Co.* v. *Commissioner*, 518 F.2d 772 (9th Cir. 1975); *Kaiser Steel Corp.* v. *United States*, 717 F.2d 1304 (9th Cir. 1983); *Imperial Colliery Co.* v. *United States*, 599 F. Supp. 653 (S.D.W.Va. 1984).*

Another line of cases supporting taxpayer's position are the strip mining cases. There, taxpayer was engaged in strip mining for coal. By state statute, strip miners had to backfill and restore the land after mining. Mining would commence in one year; the backfilling would be done in a later year. The issue was the deductibility of taxpayers' future costs for future backfilling. The courts concluded that the "all events" test had to be applied in a prac-

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* Contrary to the government's assertion (Pet. Br. 40 n.14), the workmen's compensation cases are not distinguishable from the case at bar. In the workmen's compensation cases, the employee had been injured; here the employees had been to the doctor. There the employee had filed a claim; here some employees had filed claim forms by year-end, yet here the government asserts that processing must be complete. But in workmen's compensation cases future paperwork and processing would be required since future medical benefits and wage claims (for medical services rendered and wages lost in the future) would have to be processed. There the government says liability was conceded; here there is no contest. Furthermore, the future medical bills in the workmen's compensation area would only be paid if properly related to the work-related injury; unrelated, extraneous matters would not be accepted there, just as charges not authorized by the plans are not accepted here. To the extent there are differences, the case for deduction is stronger in the case at bar because the medical services have already been received.

tical way and held that the liability to backfill was fixed and definite when the mining occurred, even though the services to be rendered to backfill the land would be performed in the future. *Harrold* v. *Commissioner*, 192 F.2d 1002 (4th Cir. 1951); *Denise Coal Co.* v. *Commissioner*, 271 F.2d 930, 934-37 (3d Cir. 1959); *Ohio River Collieries Co.* v. *Commissioner*, 77 T.C. 1369 (1981).

The instant case is a stronger and easier one for a deduction than either the workmen's compensation or strip mining cases, where deductions were allowed for services to be performed in the future. Here, the medical services have been performed by the end of 1972. In all of these cases, as in the instant case, there would be paper processing in the future. Bills would come in. Proper charges would be paid; improper ones would not.

E. The Medical Benefit Claims Were Not Contested.

The government further suggests that liability cannot exist until processing is complete because there might be some contested claims. This argument is untenable. The proven fact in this case is that medical benefit claims were not contested. (Pet. App. 12a.) The uncontradicted testimony was that medical benefit claims processing was nonadversarial and did not result in disputes. In ten years there were only *two* lawsuits regarding medical benefits. (J.A. 91, 171-172.) As the trial court found, claims were processed to pay the employees all they were due under the plans. (Pet. App. 12a.) Rather than reject claims, additional documentation was sought so claims could be processed and paid.

To the extent the raw employee medical bills submitted were not paid in full, it was not because of any dispute or contingency, but because the plans, by their terms, only covered most, but not all, expenses (*e.g.*, semi-private

room costs rather than private room costs, major medical paid 80% of costs). Even so, taxpayers actually reimbursed their employees, in the aggregate, for some 90% of all medical costs (covered and not covered) incurred by the employees. (J.A. 91.) There was no showing that properly covered amounts were not paid. The trial court correctly recognized that the 10% of the gross medical bills which were not paid were not entitled to payment under the plan provisions. Thus, there was no nonpayment due to any contest, and the fact that only 90% of gross costs were covered by the terms of the plans did not render the liability contested or uncertain (Pet. App. 12a-13a.).*

Liabilities must actually and affirmatively be disputed to make them contested and thus nondeductible. *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516 (1944). Treasury Regulation § 1.461-2(b)(2) defines "contest" as requiring a "bona fide dispute" and an "affirmative act denying" the liability. (See Addendum.) The Claims Court has ruled that affirmative action denying the liability by the taxpayers is required for a "contest"; mere failure to "acknowledge" liability is not enough. *Hollingsworth, Jr.* v. *United States*, 568 F.2d 192, 198 n.10 (Ct. Cl. 1977). Routine processing procedures, such as those involved here, do not establish any contest. *See, Hershey Creamery Co.* v. *United States*, 101 F. Supp. 877, 884 (Ct. Cl. 1952); *Dravo Corp.* v. *United States*, 348 F.2d 542 (Ct. Cl. 1965); *Japanese Trading Co.* v. *Commissioner*, 25 T.C.M. 441 (1966). The government's speculation about nonexistent contests is the type of remote and speculative possibility which this Court refused to countenance in *Hughes Properties*.

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* In any event, the taxpayers were accruing only for the amounts actually covered by the plans, not for excess portions of bills which were not covered. (Tr. 147, 229.) Consequently, they are entitled to the deduction. Treasury Regulation § 1.461-1(a)(2) specifically allows deduction of any "undisputed" amount or portion.

F. Payment Did Not Have To Be Presently Due.

By its staunch resistance to a deduction for existing liabilities which will be paid in a future year, the government really seeks to impose upon these accrual-basis taxpayers the cash basis of accounting for these expenses. Under the government's view, it will not be satisfied until payment has actually been made or is ready to be made. In other words, it is the very nature of accrual accounting to which the government objects.

In its brief, the government confuses the matter of having a liability to someone (although perhaps payable at a later date) and having a liability for which payment is presently due. The "all events" test requires the former, but it definitely does not require that such obligation be presently due and payable. *United States* v. *Anderson, supra* (the munitions tax deductible in 1916 was not due and payable until 1917); *American National Co.* v. *United States*, 274 U.S. 99 (1927); *Brown* v. *Helvering*, 291 U.S. 193 (1934).

This Court's recent *Hughes Properties* decision quoted with approval (106 S.Ct. at 2099) the following language from *Helvering* v. *Russian Finance & Construction Corp.*, 77 F.2d 324, 327 (2d Cir. 1935):

> "The existence of an absolute liability is necessary; absolute certainty that it will be discharged by payment is not."

In *Hughes Properties* the jackpot liability which was deducted was an amount listed on a machine which no one had won yet. The government's basic argument was that there was no liability until the lucky player won. It was concerned that there was no existing obligee who could enforce any liability. This Court held that the winning play was not a prerequisite for liability for the "all events" test. Clearly, until the winning play occurred in

the future, the casino had no present obligation to pay anyone. In the instant case, since employees have received medical services prior to year-end, obligees who can enforce the liability exist. That payment is not due them until the mechanics of claims processing are complete should not, on the basis of *Hughes Properties*, preclude liability under the "all events" test.

G. Taxpayers Did Not Need To Know The Identity Of The Benefits Recipients At Year-End.

The government also argues that liability is not fixed because taxpayers did not actually know the precise identity of all the employees who had received medical services by year-end and the amounts of each claim. Of course, taxpayers did know the names of those employees who had submitted forms which were undergoing processing. While taxpayers did not have this knowledge for those employees who had not yet filed claims, this fact is irrelevant, and it does not transform a fixed liability into a contingent, nondeductible item.

The liability at issue here is not for services to be performed in the future for employees whose identity will be determined by future events. (Tr. 146, 228-229.) Here the liability was fixed because at the end of 1972 services had in fact been received by specific identifiable persons who were members of a fixed group: taxpayers' covered employees and their eligible dependents. The taxpayers did not actually know all of the names since they had not collected this information. But since the medical services had been received, the liabilities were fixed, and the identities of the specific people were knowable. The taxpayers could have canvassed all of their employees in December of 1972 to ascertain who had claims for medical benefits which had not yet been filed. This is sufficient. As stated

by the court in *Uncasville Mfg. Co.* v. *Commissioner*, 55 F.2d 893, 895 (2d Cir. 1932),*

> All the facts upon which the calculation depended had been fixed before the expiration of the year 1918. . . . The computation was uncertain, but its basis was unchangeable; it was unknown, not unknowable on December 31, 1918. That is the test. . . .

Indeed, since the claimants were knowable, taxpayers more than satisfied the legal requirements. A number of cases establish that taxpayers did not need to have a roster of the actual names of all persons receiving medical services in 1972—even if the identities of those persons had been not only unknown but also unknowable. In *Hughes Properties*, *supra*, the government's argument that the winning jackpot player's identity was required was rejected.

> The Government misstates the need for identification of the winning player. That is, or should be, a matter of no relevance for the casino operator. The obligation is there, and whether it turns out that the winner is one patron or another makes no conceivable difference to the basic liability. 106 S.Ct. at 2097.

In *Hughes Properties*, since no one had in fact won the jackpot, the identity of the winner was not only unknown but unknowable, yet that was sufficient. But in the instant case, specific employees had actually been to the doctor by year-end, so their identities, although not known were knowable because taxpayers could have canvassed their 56,000 employees. These employees who had received services existed and would not change. Indeed, at the oral argument in *Hughes Properties*, the government

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* *Uncasville* is an opinion by Judge Learned Hand, which was cited with approval by this Court in *Brown* v. *Helvering*, 291 U.S. at 200 n.6 (1934).

conceded that knowledge of the identity of the obligee is not required by the "all events" test.* (No. 85-554, Transcript of Oral Argument 11-12.)

In *Washington Post Co.* v. *United States*, 405 F.2d 1279 (Ct. Cl. 1969), the issue was whether the taxpayer (a newspaper) could deduct the amount entered on its books as due under a profit-sharing arrangement for its dealers. No money had actually been set aside or paid out to a third-party custodian. There were individual accounts for dealers, but the dealers were not vested in certain portions of the account balances, which amounts could be forfeited. Thus, the ultimate recipients as well as the time of payment and amount of payment were unknown at year-end, and indeed unknowable. The Court of Claims rejected defendant's argument that these uncertainties made the liability contingent, and the full deduction was allowed. The court, taking a practical view of the situation, concluded that the amount which was to be paid in total was fixed and the uncertainties as to specific people, payouts, etc., did not make the liability any less real, fixed or certain. The Court stated: "the 'all-events' test . . . is not inflexible; when the liability itself is clearly fixed, as in this case, other uncertainties do not necessarily destroy that initial certainty." 405 F.2d at 1284.

In *Lukens Steel Co.* v. *Commissioner*, 442 F.2d 1131 (3d Cir. 1971), the taxpayer was to make payments to a

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* QUESTION: [From the Court] "Why should the identity of the eventual payee matter, as long as it's certain there will be a payee? . . ."

MR. LAUBER: "Well, I would agree with the premise that the ultimate identity of the payee is not important. But we think what precludes the deduction here is that nobody has won the jackpot. It's not that someone has won and we don't know who. . . ." (Transcript 11-12.) Here, someone has won, yet the government's objection is that "we don't know who."

trust fund under a supplemental unemployment benefit plan for laid-off workers. Part of the payment was currently paid in cash; the balance was merely accrued on taxpayer's books. It was unclear when the accrued balance would be paid to the trust. Under the plan, it was also impossible to determine which employees would receive benefits, since payments would be made for layoffs in the future. The court held that the liability to pay the accrued amount to the plan in the future was sufficiently fixed and certain to be presently deductible. *Accord, Inland Steel Co.* v. *United States*, 212 Ct. Cl. 558 (1976).

Lukens Steel was relied on by the Tax Court in *Ohio River Collieries*, one of the strip mining cases. The Tax Court stated: "The fact that the recipients of petitioner's reclamation payments and the relative portions that they would receive were not identified in the tax year is irrelevant." 77 T.C. at 1375. In stark contrast to the case at bar, those recipients could not be known in the tax year since the reclamation services had not been rendered.

From the foregoing cases, it can be seen that deductibility of the accrued liability for services received is not precluded by the fact that taxpayers did not know exactly which of its employees covered by the plans had received the benefits.* The trial court's rejection of defendant's argument on this point was correct. (Pet. App. 14a-15a.)

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* This lack of knowledge did not last long. Most claims for 1972 liabilities came in early in 1973 and, except for very minor amounts, were promptly processed and paid in 1973. (J.A. 35, 93.) Thus, the government's contention (Pet. Br. 36 n.11) that taxpayers were not obligated to pay claims more than two years old has no real application to the actual facts.

H. The Government's Cases Are Inapposite.

The government seeks to buttress its claim that taxpayers must have a claim filed and processed for each employee before year-end on the theory that otherwise taxpayers are impermissibly attempting to deduct a future, contingent liability based solely on their ability to predict future liabilities. This is a distortion of the taxpayers' position.

Taxpayers in this case are not attempting to deduct future, contingent liabilities based on the premise that they are able to estimate the amount with reasonable accuracy. They are not seeking to deduct in 1972 the amount of medical expenses to be incurred in 1973 for services received in 1973 on the theory that they can reasonably estimate what that amount will be. Instead, taxpayers are seeking a deduction for existing liabilities for services received in 1972. These services had already been received by specific individual employees, which is all that is required. The events fixing liability had already occurred. The government's cases on this point are all clearly beside the point because they involved contingent or contested liabilities and this case does not.

Thus, *Brown* v. *Helvering*, 291 U.S. 193 (1934), involved a proposed deduction for commission refunds which might have to be made by an insurance agent if policies were cancelled in the future. This is a typical situation of a contingent liability which might arise depending upon the occurrence of future events (there, the cancellation of policies). The fact that the taxpayer could reasonably estimate the amount of future cancellations could not eliminate the requirement that a fixed liability presently exist to satisfy the first part of the "all events" test.

In *Hughes Properties, supra*, this Court found that the government's "heavy reliance" on *Brown* v. *Helvering* was "misplaced" (106 S.Ct. at 2097-2098):

> because the actual event that would create the liability—the cancellation of a particular policy in a later year—'[did] not occur during the taxable year' . . . but rather occurred only in a later year in which the policy was in fact cancelled. Here, however, the event creating liability . . . was the last play of the machine before the end of the fiscal year, since that play fixed the jackpot amount irrevocably.

Similarly, in the instant case, as discussed above, the trip to the doctor or hospital fixed the amount of the medical benefits, and the medical benefits for which deduction is sought are only those which were received in 1972.*

American Automobile Ass'n v. *United States*, 367 U.S. 687 (1961), concluded that the taxpayer, an automobile club, could not defer membership income which it had already received on the ground that it would be required to provide services to members upon request over a future period of time. The taxpayer tried unsuccessfully to persuade the Court to allow such a deferral based on the claimed accuracy of its estimates of when and in what amounts future membership service would have to be provided. This was, of course, a contingent matter dependent upon the occurrence of future events. The events causing members to request service had not yet occurred, and the members had, therefore, not requested service. Consequently, the deferral of income was properly rejected.**

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* In *Brown*, the cancellation was necessary to fix the liability. Of course, even after a cancellation notice came in, processing would have to occur to determine pursuant to the policy the correct amount of the refund according to the terms of the policy. There is no suggestion in *Brown* that the liability would await not only cancellation but also subsequent processing. The ministerial processing which occurred in this case serves the same function, and has the same lack of significance.

** The government's other cases also involve contingent, future liabilities. In *Trinity Construction Co.* v. *United States*, 424 F.2d

(Footnote continued on following page)

In each of these cases, the taxpayers attempted to deduct a liability or defer income to match expenses which would not arise until the occurrence of contingent future events (*e.g.*, the cancellation of policies or the demand for services by customers) on the theory that they could accurately estimate the amount that those liabilities would add up to when they did accrue. In short, the taxpayers were trying to use their claimed ability to satisfy the second "reasonable amount" prong of the "all events" test to bypass the first "fixed liability" prong. Those arguments were rejected because the existence of a fixed liability is required before the amount issue could be reached.

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footnote continued

302 (5th Cir. 1970), an employer was obligated to pay premiums on life insurance policies for certain employees but only if the particular employee was alive when the premium was due. In *Bennett Paper Corp.* v. *Commissioner*, 699 F.2d 450 (8th Cir. 1983), a company was obligated to pay bonuses in later years, but only if the employee was still employed when the payment came due. In *World Airways, Inc.* v. *Commissioner*, 62 T.C. 786 (1974), *aff'd*, 564 F.2d 886 (9th Cir. 1977), the taxpayer had an obligation to perform and pay for overhauls on airplane engines and frames in the future, but only if the airplanes continued in service long enough to log enough flight hours so that the overhaul was in fact due. Furthermore, the taxpayer had contracted with third parties to perform the overhauls, and the taxpayer was only liable to pay for overhauls actually performed. Each of these cases is inapposite to the instant case. In each of these cases, a future event had to happen before any underlying liability came into existence. That is not the case here. Once the employee had been to the doctor and received the medical services, the underlying liability attached. All that remained to be done was the clerical process of calculating the amount of the payment under the terms of the plan. The employee did not have to survive and be living as of the payment date, as in *Trinity Construction*. Nor did he have to continue in taxpayers' employ until payment, as in *Bennett Paper*. The medical services had already been rendered and received by year-end. Taxpayers are not trying to deduct in 1972 an estimate for medical services to be performed in later years, as was, by analogy, the situation in *World Airways*.

In *Milwaukee & Suburban Transport Corp.* v. *Commissioner*, 18 T.C.M. 1039 (1959), *rev'd*, 283 F.2d 279 (7th Cir. 1960), *vacated and remanded*, 367 U.S. 906 (1961), *aff'd on remand*, 293 F.2d 628 (7th Cir. 1961), the claims at issue were personal injury and property damage claims (tort claims), which were contested. As such, according to well-established authority,* they could not satisfy the first part of the "all-events" test. Furthermore, the amount of the liability also depended on the outcome of the contest. The government's extended discussion of this case (which has a confusing history) is irrelevant since this case is inapposite to the instant case where the medical benefits were uncontested contractual liabilities.

Similarly, *Lucas* v. *American Code Co.*, 280 U.S. 445 (1930), is inapposite as the government's own description of the case shows. (Pet. Br. 17, 39.) *Lucas* involved a contested liability for breach of contract which was in active litigation and the amount of which depended upon the outcome of the lawsuit.

Finally, the government's "aggregate estimate" objection is really a quarrel with the method taxpayers used to determine the amount of their liability. Neither the regulations, nor the cases prescribe any particular method of calculation or condemn a particular calculation because it is made on an aggregate rather than individual-by-individual basis. Consequently, the lower courts were correct in holding that the second prong of the "all events" test had been satisfied. In this Court, however, the short answer to the Government's argument is that the "amount" issue is foreclosed because the Government decided not to seek review of that issue. (Pet. 13 n.2; Pet. Br. 33 n.10.)

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* *Dixie Pine Products Co.* v. *Commissioner*, 320 U.S. 516 (1944).

II. THE GOVERNMENT'S RED HERRINGS.

Based on the trial evidence, both courts below found that taxpayers satisfied the general rule applicable to all accrual-basis taxpayers: the "all events" test. In this Court, the government directs the first part of its brief to a series of irrelevant arguments, delaying to page 30 its discussion of the "all events" test, the only issue properly before this Court. Regardless of the prominence given to these irrelevancies in the government's brief, however, they are still red herrings in this case.

Reserves. The government argues at length that no "reserves" are proper deductions unless explicitly allowed by the Internal Revenue Code. Reduced to the essentials, the government's position is: call it a "reserve" and the government wins. Of course, that is not true.

The government's underlying premise—that all reserves necessarily constitute contingent, future liabilities—is simply fallacious. A reserve is merely an accounting device to make provision for a liability which has not yet been paid—any kind of liability. A reserve may be set up for a contingent liability. But a reserve may also be set up for a fixed and certain liability, *e.g.*, a fixed liability to pay X dollars on March 15th of the next year. The "all events" test issue is whether the liability reserved for is fixed or contingent, not what label is attached to the accounting entry.* Certainly, a taxpayer cannot be denied

* The government asserts that taxpayers admit that the reserves used here were "garden variety" reserves and that self-insurance reserves are generally not deductible. (Pet Br. 30.) In fact, taxpayers have admitted none of these things but have merely declined to discuss irrelevant issues. The relevant question is the nature of the liability (in this case, fixed and definite) rather than the fact that a reserve has been established or the mechanics of reserve accounting.

a deduction for a fixed liability simply because he set up a reserve for it.

Cases such as *Commissioner v. Hansen*, 360 U.S. 446 (1959); *Brown v. Helvering*, *supra*; and *Lucas v. American Code Co.*, *supra*, cited by the government, do not support the proposition that all reserves are nondeductible. The government's own description of these cases (Pet. Br. 17) shows that they involved contingent or contested future liabilities, liabilities which did not satisfy the "all events" test.* Moreover, numerous cases show that the government's "label-it-a-reserve-and-I-win" position is erroneous. In *Anderson*, *supra*, the seminal "all events" case, this Court held that a "reserve for taxes" was deductible. In the workmen's compensation and strip mining cases discussed above, "reserves" labeled as such were at issue and were held to be deductible.

The Tax Court in *Buckeye International*, *supra*, exhibited a keen insight into the real significance of this type of government argument (49 T.C.M. at 385):

> [The Commissioner] raises several arguments which indicate his dissatisfaction with the accrual method of tax accounting. [The Commissioner] asserts, for example, that [the taxpayer] has attempted to deduct

* The government's cases which merely describe the mechanics of reserves (Pet. Br. 16 n.2.) obviously do not constitute authorities against a deduction. Furthermore, the government's lengthy (Pet. Br. 4-6, 24-25) and inaccurate (see J. A. 27-32) description of the history of taxpayers' reserve is also irrelevant to the issue before this Court. Satisfaction of the first prong of the "all events" test does not turn on whether taxpayers had been insured for the medical benefits and then switched to self-insurance, or had started the benefits plans fresh with no history of insurance; nor does it turn on whether the insurance companies returned money to taxpayers because taxpayers had assumed the outstanding liability for unpaid claims from the prior insured period, or whether taxpayers had set up an entirely new reserve on December 31, 1972.

> a reserve and that "[i]n the absence of specific statutory authorization, federal income tax deductions for reserves for future liability are not permitted." We agree that a taxpayer may not deduct estimated future expenses for which liability does not exist. [Citation omitted.] Nowhere does [the Commissioner] define the term "reserves," however. Simply using the term to describe the deductions in issue is insufficient. . . . Where, as in the current case, the liability in question satisfies both requirements of the all events test, accrual is proper despite the label used by [the Commissioner].

Financial Accounting. It is true, as the government states at length, that financial accounting, premised on principles of conservatism, may require reserves for contingent or contested liabilities which are not allowed for tax accounting purposes (because contingent and contested liabilities are not deductible under the "all events" test); but that is also irrelevant to this case. Taxpayers have not sought to justify their deduction on the ground that it accords with proper financial accounting principles, although they believe that it does. No evidence on financial accounting was introduced or relied upon. Instead, the taxpayers have always recognized and presented their case on the admittedly controlling issue—whether their liability is a fixed and certain liability which satisfies the "all events" test. Certainly no taxpayer has been denied a deduction for a fixed liability merely because making provision for that liability also happened to be in accordance with financial accounting principles. A similar "financial accounting is not tax accounting" argument based on the same government authorities was found to be "unpersuasive" by this Court in *Hughes Properties*, 106 S.Ct. at 2098.

Repeal of Section 462. The government makes an argument based on the repeal of Section 462 of the Internal

Revenue Code, which would have allowed the deduction of certain reserves for expenses which otherwise would have been required to be deducted in a later year. The government argues that this repeal somehow establishes that taxpayers' reserve for a fixed liability which satisfies the "all events" test is not deductible. This argument is wrong, as this Court found in *Hughes Properties*.

> The fact that Congress once briefly adopted statutory provisions that specifically would have permitted a taxpayer to deduct anticipated expenses by a reserve mechanism is hardly significant. 106 S.Ct. at 2098 n.4.

If the liability is fixed, it was deductible before and after repeal of Section 462.

Insurance. The government argues that, since insurance companies are subject to specific Code provisions which allow deductions for reserves, taxpayers, which are not insurance companies, cannot deduct their reserve for 1972 medical expenses. (Pet. Br. 26-29.)

Again, this argument is wholly beside the point. Insurance companies are permitted to deduct all kinds of liabilities including many which are contingent or contested. Indeed, the reserves of casualty companies which cover situations such as injury claims from auto accidents are composed largely of estimated amounts which will be due only after the resolution of contested claims.

But taxpayers have never argued that they are entitled to the benefit of the Code sections applicable to insurance companies. They have never argued that they are *de facto* insurance companies. They have never claimed the right to deduct contingent or contested liabilities. Consequently, it does not matter whether (as the government argues) "self-insurance" is a misnomer because no insurance is involved. The government cites no case that has held that

the existence of the special insurance company provisions means that a liability which meets the "all events" test—the test applicable to ordinary taxpayers—cannot be deducted by those ordinary taxpayers.*

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* The "self-insurance" cases cited by the government all involved liabilities which were contingent on future events or contested. Since deductions of such liabilities could not be justified on the basis of the "all events" test, the taxpayers in those cases set up captive or wholly-owned insurance companies and then sought deductions for the payments made to these companies as deductible insurance premiums under Section 162 of the Code. The courts disallowed the deductions on the basis that they represented nothing more than additions to a self-insurance reserve set up to cover the future contingent liabilities at issue.

The government cites *Bituminous Casualty Corp. v. Commissioner*, 57 T.C. 58 (1971), for the proposition that "the deduction of casualty insurance reserves by ordinary accrual-basis taxpayers is 'fundamentally at odds with the all events test.' " (Pet. Br. 30-31.) In fact, the Tax Court's holding was that it would be unfair to limit insurance companies to deductions authorized by the "all events" test. In the passage quoted by the government, the Court pointed out that the particular reserves sought to be deducted could not qualify under the "all events" test because the liabilities were either contested or contingent on future events. The Court's statement in context is as follows (57 T.C. at 77):

> "The deduction of these loss and loss adjustment expense items is fundamentally at odds with the 'all events' test: the items include amounts for liabilities which are not established, but, on the contrary, vigorously contested; they include, in the case of the loss adjustment items, expenses which will not only be paid in the future, but which are attributable to events which will not occur until the future, including future overhead. . . . "

CONCLUSION

For all of the foregoing reasons, the judgments of the United States Claims Court and the United States Court of Appeals for the Federal Circuit should be affirmed.

Respectfully submitted,

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ADDENDUM

Treasury Regulation § 1.461-2(b)(2): "Any contest which would prevent accrual of a liability under Section 461(a) shall be considered to be a contest in determining whether the taxpayer satisfies paragraph (a)(1)(i) of this section. A contest arises when there is a bona fide dispute as to the proper evaluation of the law or the facts necessary to determine the existence or correctness of the amount of an asserted liability. It is not necessary to institute suit in a court of law in order to contest an asserted liability. An affirmative act denying the validity or accuracy, or both, of an asserted liability to the person who is asserting such liability, such as including a written protest with payment of the asserted liability, is sufficient to commence a contest. Thus, lodging a protest in accordance with local law is sufficient to contest an asserted liability for taxes. It is not necessary that the affirmative act denying the validity or accuracy, or both, of an asserted liability be in writing if, upon examination of all the facts and circumstances, it can be established to the satisfaction of the Commissioner that a liability has been asserted and contested."

(9)

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No. 85-1385

In the Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

REPLY BRIEF FOR THE UNITED STATES

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1. Pursuant to its collective bargaining agreements, respondent reimburses its employees for some of their medical expenses, but not until all of the following events have occurred: 1) an employee receives and is charged for covered medical services; 2) the employee files a claim for reimbursement supported by the appropriate documentation; and 3) respondent processes the claim and approves all or part of it for payment. For federal income tax purposes, however, respondent contends that the first step in this series of events—the receipt of covered medical services—is the final event that "fixes" and creates a definite obligation to make reimbursement. Hence,

respondent contends that it was entitled to deduct $5.5 million on its 1972 tax return as an expense "incurred" during that year (I.R.C. § 162) for amounts that respondent estimated (based on past experience) that it would be required to pay in future years for employee medical services that were received in 1972, but for which claims either had not been filed or had been filed but not yet approved during that year. Thus, although the filing of a claim by the employee and processing and approval of that claim undisputedly are treated by respondent as conditions precedent to payment, respondent maintains that these conditions can be ignored for tax accounting purposes and therefore that the "all events" test (Treas. Reg. § 1.461-1(a)(2)) does not prevent it from accruing a deduction for payment of medical expenses before employee claims for those expenses have been filed or approved.

Respondent reaches this counterintuitive legal conclusion primarily by *ipse dixit* (see Resp. Br. 5, 17-18). The one reason given is the fact that once an employee has incurred covered medical expenses, respondent loses the ability to avoid reimbursement liability by terminating the plan (see Resp. Br. 17). It is true, of course, that at that point the employee has obtained a right *to seek reimbursement* under the plan; therefore, respondent may well have lost the ability to avoid a potential liability by its own unilateral action. But that is not the same as saying that a fixed and definite liability has arisen. Any potential liability that has arisen as a result of the employee's doctor visit is uncertain and contingent until the occurrence of two future events—the filing of a claim and the processing and approval of all or part of that claim. It is only after the completion of

these two additional steps, which may in any individual case be time-consuming or quite simple, that respondent acknowledges any liability to reimburse a particular employee for particular medical services, and until that time its potential liability for such reimbursement is not sufficiently definite to be accrued under Section 162.

This is not to deny that it is highly probable that many of the covered medical expenses incurred in 1972 will ultimately be claimed by employees and reimbursed by respondent. But the "all events" test is not satisfied by a high probability that obligations will become fixed in the future. "Financial accounting * * * is hospitable to estimates, probabilities, and reasonable certainties; the tax law, with its mandate to preserve the revenue, can give no quarter to uncertainty." *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. 522, 543 (1979).[1]

2. We contended in our opening brief (at 35-36) that an unconditional obligation to make a payment

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[1] The indefinite nature of this potential liability is highlighted by the method that respondent must use to compute the amount of its reserve for incurred-but-not-reported claims. Respondent has no knowledge of any facts respecting any particular employee or doctor visit; instead, it bases its reserve on an aggregate estimate of future liability that is statistically derived from past experience. Such an aggregate statistical estimate is incompetent as a matter of law to establish "the fact of the liability" as required by the first prong of the "all events" test. By contrast, the cases on which respondent relies to support its accrual theory all involved deductions that were premised on actual facts known to the taxpayer at the close of the tax year, not merely on statistical projections based on prior years. See, *e.g.*, *United States* v. *Hughes Properties, Inc.*, No. 85-554 (June 3, 1986); *United States* v. *Anderson*, 269 U.S. 422 (1926).

to an employee cannot possibly arise until that employee files a claim for reimbursement. Respondent does not dispute that, if no claim is filed, the plan does not oblige respondent to make any reimbursement for covered medical charges, and in fact respondent does not make any payment in those circumstances. For that reason alone (see Gov't Br. 38 n.13), respondent's attempt to accrue a deduction in 1972 for the estimated amount of medical charges incurred in that year, but for which claims had not yet been (and might never be) filed, manifestly fails the "all events" test.

Respondent makes little effort to answer this contention. It lamely states that "[t]here is no evidence that any significant number of employees failed to file claim forms" (Resp. Br. 13). Of course, the burden is on respondent to establish its entitlement to the deduction it seeks (*Helvering* v. *Taylor*, 293 U.S. 507, 514-515 (1935)); the government has no responsibility to demonstrate the extent to which employees ultimately fail to comply with the precondition to reimbursement established by respondent's plan—a negative statistic that probably cannot be determined. The point of the "all events" test is to eliminate the need for such "conjecture" (Resp. Br. 18) by prohibiting the accrual of expenses until *all* the conditions necessary to fix the obligation have been satisfied; in this case, those conditions clearly include the filing of a claim. At any rate, there is no dispute that at least some eligible employees fail to claim reimbursement for covered medical services,[2] even though the extent of such failure to file

[2] Respondent does not assert that all eligible employees claim reimbursement for all their covered medical services; it disputes only the notion that the number of employees who fail

claims may not be known. Therefore, it is manifestly premature for respondent to take a deduction for medical charges incurred by employees, but for which no claim for reimbursement has been filed.

Respondent also contends (Br. 18-21) that the fact that employees sometimes do not claim reimbursement for medical expenses does not mean that respondent did not have an unconditional obligation to make that reimbursement at the time the medical services were rendered; rather, respondent characterizes the failure to file a claim as "a waiver of an already accrued right to benefits" (Resp. Br. 18). This contention is plainly mistaken. It is true, of course, that it is possible for payment to be waived when there is a fixed obligation to pay, such as when a creditor forgives a debt. But that is not the situation here. There is no obligation on respondent's part to make a payment until the employee files a claim. Until that time, the employee has no basis for demanding payment, and he clearly could not prevail in a lawsuit seeking to collect reimbursement from respondent. By failing to file a claim, he is not forgiving an existing obligation to pay; rather, he is failing to take a step that would lead to the creation of such an obligation.

3. Respondent contends (Br. 15-16) that there is no legal issue for this Court to resolve; it argues that the "findings" of the trial court and the record in this case conclusively establish as a factual matter that respondent had a fixed and definite obliga-

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to do so is "significant" (Resp. Br. 18) or "substantial" (Resp. Br. 16). The record does not address this precise issue, but it does establish that employees sometimes file their claims later than the time limits specified in the plan, which prevents them from triggering an obligation on respondent's part to make reimbursement (see J.A. 130-131; Gov't Br. 36 n.11).

tion to make reimbursement at the time covered medical services were rendered (see Resp. Br. 15-29). This is plainly incorrect. Based in large part on its reading of *Kaiser Steel Corp.* v. *United States*, 717 F.2d 1304 (9th Cir. 1983), which in our view was wrongly decided (see Gov't Br. 41 n.14), the trial court reached a legal conclusion that the events following the receipt of medical services that are preconditions to reimbursement by respondent are too insignificant to prevent accrual of a deduction for the medical expenses; rather, the court concluded, "the fact of *injury* established the fact of *liability*" (Pet. App. 13a (emphasis in original)). The court made no findings of fact that would compel a judgment in respondent's favor under a correct legal analysis of the case.

The record simply does not support the weight that respondent would place on it. Respondent asserts (Br. 16) that the record establishes that "claims processing is clerical and ministerial" and "claims are not contested"; it also states that there is no evidence that any substantial number of people do not file claims. If anything, the record is directly to the contrary. As pointed out above (note 2, *supra*), the record establishes that some claimants fail to take advantage of their right to reimbursement by filing a timely claim. And, while there may be some dispute about the extent, the record clearly establishes that some benefit determinations are contested.[3]

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[3] Various figures were put forth in the testimony in the trial court concerning lawsuits brought to challenge benefit determinations. Aetna reported 229 suits regarding the issue of prevailing rates alone (J.A. 116-117) and 199 suits in 1982 and 129 suits in 1979 on other issues (J.A. 135). Prudential reported 96 suits in 1982, and two suits that the witness person-

In stating that the computation of the allowable reimbursement is "ministerial," respondent would have us believe that its plan is so detailed and precise that the calculation of benefits under the plan is like using multiplication tables—*i.e.*, that different claims processors would invariably arrive at the same benefit figure for the same claim and that the employee would have no basis for disagreeing with that determination (see Resp. Br. 23). We have no doubt that this may be true for the simpler claims and, indeed, for the majority of claims. But it plainly is not true across the board that respondent's plan leaves no room for uncertainty or dispute with respect to any benefit determination.

The possible pitfalls of a benefit calculation are illustrated, rather ironically, by a simple example given by respondent in its brief of a claim that could be "processed routinely in a few minutes" (see Resp. Br. 22-23). In respondent's example, the plan provides a $60/day maximum for hospital room charges, and the employee is charged $70/day for three days. Respondent explains that the employee—once he files a claim—is clearly entitled to reimbursement only of $180 and would know from reading the plan that the excess $30 was not reimbursable. Perhaps that is clear as day, and perhaps respondent is right that if this claim "were submitted to several different processors, they would reach the same result" (*id.* at 22). But it bears mentioning that if this claim had

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ally recalled going back to 1972 involving respondent (J.A. 171-172). As we noted in our opening brief (at 37 n.12), because of the relatively small sums that are usually at stake, one would expect the number of lawsuits challenging benefit determinations to be dwarfed by the number of contested claims that do not result in litigation.

been presented to respondent's Director of Employee Benefits, who testified at trial as to the operation of respondent's plan, he would have reached a different result—authorizing payment of $204 reimbursement by crediting the excess $30 at 80 percent (see J.A. 92).

The record demonstrates that the plan contains other ambiguities that necessitate the exercise of judgment by the claims processor—judgment that may legitimately be challenged by the employee. The claims processor may be called upon to decide whether a condition "may be judged chronic" (J.A. 128), whether a prior course of treatment is sufficiently related to a claim to justify denial on "pre-existing condition" grounds (J.A. 129), or whether "extenuating circumstances, like getting [the doctor] out of bed at 3 o'clock in the morning," justify a higher fee (J.A. 124). The record emphasizes respondent's need to have the opportunity to "evaluate" and "investigate" claims (J.A. 131), and respondent in its brief (at 8-9) lists various circumstances in which the claims processor would have to solicit further information from the employee's doctor before deciding upon the proper reimbursement. These facts hardly accord with respondent's characterization of the benefit-determination process as plugging numbers into a simple formula. In sum, there is a sufficient degree of uncertainty in the benefit-determination process that the step of approving the claim (which, after all, respondent views as critical to making its own decision to pay) cannot be dismissed as "ministerial" and thereby be ignored for purposes of applying the "all events" test.

4. Respondent mischaracterizes our position in stating that our view of the case is "call it a 'reserve' and the government wins" (Resp. Br. 39).

This case does not turn on semantics. Clearly, a taxpayer may set up an account reflecting expenses that have properly accrued and label it a "reserve" without losing the right to deduct the accrued amounts. But Congress quite clearly has provided that a taxpayer generally cannot claim a deduction under the accrual method of tax accounting for the typical type of reserve—one set up for financial accounting purposes to reflect a probabilistic estimate of future liabilities that are not presently fixed. The fact that respondent's IBNR reserve is precisely this type of reserve account—computed not by reference to any known facts concerning the potential liability, but rather solely as a statistical estimate based on past experience—is thus highly probative. When one considers that respondent quite literally took the IBNR reserve off the books of its insurance companies and placed the reserve on its own books, that Congress found it necessary to enact special provisions enabling insurance companies to deduct such reserves (see Gov't Br. 23-29), and that Congress enacted and then quickly repealed legislation that would have allowed other taxpayers to deduct such reserves (Gov't Br. 19-22), that Congress did not contemplate that such reserves could be used by ordinary taxpayers to accelerate deductions under Section 162.

For the foregoing reasons and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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Solicitor General

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